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ABSTRACT

This document reports testimony presented on Medicare financing of graduate medical education, as proposed by the Balanced Budget Act of 1995. Witnesses included: (1) Timothy M. Golddfarb, Director, Healthcare Systems (Oregon), who noted the importance of graduate medical education funding to teaching hospitals; (2) Leo P. Brideau of Strong Memorial Hospital (Rochester, New York) who was concerned with protecting the program's viability; (3) Larry Wickless of the American Osteopathic Association, who hoped for increased support for graduate osteopathic programs; (4) Spencer Foreman, who spoke on behalf of the Greater New York Hospital Association concerning the importance of international medical graduates to institutions serving poor populations; (5) William E. Jacott, who spoke for the American Medical Association, which supports changes in the graduate medical education program; (6) Patrick B. Harr, who spoke for the American Academy of Family Physicians, about the physician surplus; (7) Leslie S. Cutler, University of Connecticut Health Center, who suggested establishment of medical education consortiums; (8) Anthony M. Marlon and Jerry Reeves of Sierra Health Services (Las Vegas, Nevada), who described a private-public pilot program to fund education of medical residents; (9) Mary O. Mundlnger, Columbia School of Nursing (New York), who sought funds for graduate nursing education; and (10) Lynn E. Caton, representing the American Academy of Physician Assistants, who sought to make physician assistant programs eligible for such funding. In addition to the testimony, discussions between witnesses and the committee members are also transcribed. (CH)

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TEACHING HOSPITAL AND OTHER ISSUES RELATED TO GRADUATE MEDICAL EDUCATION

ED 411 754

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JUNE 11, 1996

Serial 104–83

Printed for the use of the Committee on Ways and Means

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TEACHING HOSPITAL AND OTHER ISSUES RELATED TO GRADUATE MEDICAL EDUCATION

TUESDAY, JUNE 11, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 12:17 p.m., in room B–318, Rayburn House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 4, 1996
No. HL-19

CONTACT: (202) 225-3943

Thomas Announces Hearing on Teaching Hospital and Other Issues Related to Graduate Medical Education

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recommendations regarding Medicare's financing of Graduate Medical Education (GME). **The hearing will take place on Tuesday, June 11, 1996, in room B-318 Rayburn House Office Building, beginning at 12:00 noon.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare has reimbursed teaching hospitals for the program's share of the cost of training physicians and other health professionals, and the generally higher costs of operating teaching hospitals since the inception of the program. With the advent of the Medicare Prospective Payment System in 1983, Medicare hospital payment for graduate medical training and certain teaching hospital service costs has been separated into direct and indirect reimbursement for GME.

Medicare compensates teaching hospitals for costs directly related to the training of certain health professionals; payment includes resident salaries and fringe benefits, salaries and fringe benefits of supervising faculty, and allocated overhead costs. Medicare pays direct costs based on a prospective, capitated payments which is based on a hospital-specific per resident amount. In 1996, Medicare is expected to reimburse teaching hospitals $2.0 billion for direct costs of GME. The Medicare indirect medical education adjustment compensates hospitals for the costs of additional tests and procedures which occur in those hospitals related to the training of medical residents, as well as the fact that these hospitals tend to treat sicker, and generally poorer, elderly patients who require more intensive services. In order to cover these extra costs, teaching hospitals receive a higher payment per case than other institutions. This per case add-on is currently set at approximately 7.7 percent for each 10 percent increase in the ratio of full-time interns and residents to the number of beds in the hospital. Medicare is projected to spend $4.3 billion on the indirect medical education adjustment in 1996.

The Medicare Trustees are expected to release their report this week on the solvency of the Medicare Hospital Insurance Trust Fund -- the fund which finances Medicare's share of GME. Indications that Medicare's Part A Trust Fund is deteriorating more rapidly than was anticipated in the April 1995 Report of the Board of Trustees raise serious concerns about Medicare's ability to finance GME at current levels. The Balanced Budget Act of 1995 included major reforms in Medicare payment for teaching hospitals and GME as well as the establishment of a new trust fund to subsidize these activities.

Despite President Clinton's veto of the Balanced Budget Act of 1995, the Subcommittee remains committed to these reforms and is interested in receiving recommendations on perfecting these provisions. The Subcommittee also received testimony from the Pew Commission and the Institute of Medicine at an earlier hearing and expects to receive further comments on their recommendations at this hearing.

(MORE)

In announcing the hearing, Chairman Thomas stated: "Because of the deteriorating condition of the Medicare Part A Trust Fund and its relationship to the funding of teaching hospitals, it is essential that the Congress look at ways to reform this subsidy. The advice and recommendations of these witnesses provide an important opportunity to continue a dialogue in the Subcommittee on needed reform."

FOCUS OF THE HEARING:

The hearing will focus on the recommendations of the witnesses concerning Medicare's ability to finance GME and recommendations on GME provisions included in the Balanced Budget Act of 1995 and those presented by Pew Commission and the Institute on Medicine.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, June 25, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. The Subcommittee will come to order.

I want to welcome all of you to the Health Subcommittee's second hearing this year on the Medicare policy on payment of teaching hospitals and funding for graduate medical education.

In April, we heard from the Pew Health Professions Commission and the Institute of Medicine that the traditional role of the teaching hospital is threatened by both the challenges in the evolving health care marketplace and questions about the best role for these institutions in the future.

We also learned that the number of residents is growing, despite the oversupply of physicians, and that this growth is primarily due to the number of international medical graduate residencies.

Today, we will hear from representatives of various health care providers and from physicians and other health care professionals on their recommendations for the future of teaching hospital payment and funding for graduate medical education.

Last year, we included in the Balanced Budget Act of 1995 provisions which reformed payment for teaching hospitals and graduate medical education. In order to promote broader-based financing for both these important hospitals and for GME, we established a separate trust fund, which included funding both from Medicare and from general revenues. These reforms were, unfortunately, vetoed by the President. However, the Health Subcommittee remains committed to developing on an ongoing basis these specific reforms.

We are interested in recommendations today on how we could modify payment for teaching hospitals and graduate medical education through the kind of concept included in the balanced budget amendment, i.e., a trust fund funded from general revenues or any other ideas that you might offer this Subcommittee. We look forward to hearing from you and your suggestions in the face of unprecedented change.

Before we turn to the witnesses, I want to recognize the Ranking Member, the gentleman from California, Mr. Stark, for any comments he may wish to make.

Mr. STARK. Thank you, Mr. Chairman.

I look forward to your hearings today. I thank you for calling them. It is a topic about which I must say I am ambivalent. I have never quite decided whether we ought to legislate in this area or leave it alone.

In the last hearing on GME, both the Pew Health Professions Commission and the Institute of Medicine gave us recommendations to reduce the international medical graduate residents, but neither one really talked to us about how to help the hospitals who depend on them. And as I say, I do not think that I have an answer. There have been a few concrete suggestions. Maldistribution of physician services exists. It is like, the situation when some days there are too many English professors and not enough Political Science professors. I do not know whether we could pass a law to change that.

I do hope today's witnesses can tell us how to attract more U.S. doctors to underserved areas, expecially if we are going to limit those physicians who traditionally have taken less money to fill jobs that may or may not be more—less desirable.

According to the IOM, Institute of Medicine, report, teaching hospitals provide about 44 percent of all charity care. Both the Republican and Democratic budget plans have offered changes in graduate medical education. Some might undermine the viability of those hospitals, and I would like your comments on that. I was planning to talk about MSAs and MEWAs, but, this is such a good hearing that you have called that I will just leave it at that. I hope the witnesses can make some suggestions on which we might come together and be of any help, or if you say, just leave well enough alone and let nature take its course.

Thank you.

Chairman THOMAS. I thank the gentleman, and that is precisely why we have brought these panels together. They are, I think, quite prestigious.

Our first panel consists of Timothy M. Goldfarb, director of Healthcare Systems, Oregon Health Sciences—and there are a lot of interesting things going on in Oregon, Portland, to be specific, but Oregon in general.

We have Leo P. Brideau, general director and chief executive officer of the Strong Memorial Hospital, Rochester, New York, and chairman of the board of trustees, Healthcare Association of New York State. And, we want to hear from not only the State of New York, but also the city of New York.

Larry Wickless, who is D.O., vice chairman, Council on Federal Health Programs, American Osteopathic Association.

Dr. Spencer Foreman, president of the Montefiore Medical Center in Bronx, New York, and you might anticipate some specific questions that would help us understand the role of international medical students, particularly at New York hospitals, where there seems to be a predominance.

If any of you have written statements, we will incorporate them as a part of the record, and you may inform us as you see fit in terms of information that this Subcommittee needs to know.

Why don't we just start with Mr. Goldfarb and go down the panel? Thank you.

I would tell you beforehand these microphones are very unidirectional, and you need them right in front of you to be able to discuss. And we have four people and three microphones, so you do the math.

STATEMENT OF TIMOTHY M. GOLDFARB, DIRECTOR, HEALTHCARE SYSTEMS, OREGON HEALTH SCIENCES UNIVERSITY, PORTLAND, OREGON, ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. GOLDFARB. Mr. Chairman, distinguished Members of the Subcommittee, my name is Tim Goldfarb. I am the director of Healthcare Systems at OHSU, Oregon Health Sciences University in Portland, Oregon. AAMC, Association of American Medical Colleges, appreciates the opportunity to offer testimony concerning the funding of graduate medical education.

I would like to leave you with a few points: One, to emphasize how important DME, direct medical education, and IME, indirect medical education, funding is to OHSU specifically and major teaching hospitals in general; two that any cut in IME funding and

DME funding is a real cut for my institution, not just a cut in the rate of growth of funding; and, thru, to emphasize there are some short- and long term ways to help major teaching institutions in our country and my institution in particular, those being the AAPCC carve-out for IME/DME, and the trust fund concept that you spoke about in the beginning, Mr. Chairman.

With respect to the work force issues and the IOM and PEW reports, AAMC offered a statement at your April 16th hearing and I will not be responding to that in my oral presentation.

I would like give a face to the policy issues that AAMC has presented to you and that face Oregon Health Sciences University. Perhaps an accident of birth, we are the only health profession school in our State. We are the only major tertiary institution in the State. And as such, we are an illustration of what can happen in a very dynamic managed care marketplace.

A little bit about my institution: We have a university hospital, a children's hospital, Dornbecker Children's Hospital, a medical school, as well as schools of dentistry and nursing, and research institutes, and a lot of dedicated men and women being educated and working there.

We have all the academic missions, and we are a significant player because of our solo nature in our market. Twelve percent of all the inpatients in our market come to OHSU. Our teaching program clearly is the largest in the State; over 90 percent of the residents and fellows in our region are affiliated with our institution, and most are educated at our institution.

Indigent care has long been part of our mission. In fact, before we went fully managed care in our State for Medicaid, one out of every five dollars was spent at OHSU for treating the poor. And, of course, we maintain our mission as a laboratory for clinical and basic research, since we are the primary recipient of peer review dollars in the State.

The market in Oregon is, frankly, something to behold if you are in our industry. Over 80 percent of the population in our metro area are in managed care plans of some type. I know you are specifically interested in Medicare. Fifty-two percent of the population in our metropolitan area are in a Medicare risk plans, which is the highest market penetration in the country.

As an aside, the second highest community is about 45 minutes to the south, Salem, the capital of our State, with 42 percent of the Medicare eligibles being enrolled in some risk plan.

Eighty percent of the Medicaid population are in capitated plans today, and there are plans to increase that level during the next 24 months. Over 60 percent of those that are covered by commercial insurance are in risk plans. So, I am painting a picture for you, I hope, of a very dynamic, competitive managed care marketplace, one in which an academic medical center has few places to maintain funding for graduate medical education. You, in fact, through Medicare, are the primary payer.

I want to emphasize that because of the pressure of managed care, our margins have been significantly reduced. In fact, my total margin at this point is about 1 percent, and the need for IME/DME funding is greater than ever before. In the short term, a carve-out for the AAPCC is critical for our institution, and in the long term,

the shared responsibility concept of the health trust fund is critically important not only for us but for other academic centers in the country.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF TIMOTHY M. GOLDFARB
ON BEHALF OF
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman, and distinguished members of the Subcommittee, I am Timothy M. Goldfarb, Director, Healthcare Systems at the Oregon Health Sciences University in Portland, Oregon. The AAMC welcomes the opportunity to testify on recommendations regarding the Medicare program's financing of graduate medical education (GME). The Association represents all of the nation's 125 accredited medical schools, approximately 400 major teaching hospitals, including 75 Veterans Affairs medical centers, the faculty of these institutions through 89 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents.

I come before the Subcommittee today to express the Association's concern about the future financing of teaching hospitals' and medical schools' special missions in a market-driven, competitive health care delivery system. This includes addressing the future role of the Medicare program in the financing of GME. The transformation of the health care system to a competitive, price conscious structure poses at least two problems for academic medicine. This change threatens:

- the fiscal stability of teaching hospitals and medical schools; and
- their ability to maintain an environment for education, research and innovation.

Before presenting our concerns about the future, however, I'd like to describe the functions and diversity of teaching hospitals and how they currently support their missions, including the importance of Medicare's participation in these activities.

The Characteristics and Roles of Teaching Hospitals

Teaching hospitals, in addition to all hospitals' mission of providing basic health services to community residents, have the responsibilities of clinical education for all types of health professionals, provision of an environment in which clinical research can flourish, and highly specialized patient care. These responsibilities are combined in many different ways in individual teaching hospitals, depending upon a hospital's mission, its role in the community, the resources available to it, its past history and its view of the future. As a result, a vast continuum of diverse teaching hospitals exists.

Graduate Medical Education. Participation in graduate medical education programs is the characteristic that, by definition, separates teaching from non-teaching hospitals. Upon completion of medical school, physicians continue their medical education by completing at least three years of training in residency programs. While some residencies are based outside the hospital, most graduate medical education is sponsored by hospitals. Medical schools and teaching hospitals have devised a range of relationships for the conduct of graduate medical education. At one extreme, the "freestanding" residency is established, staffed and controlled by the individual hospital. At other end of the continuum, the residency program is offered jointly by the medical school and one or more hospitals. Along the continuum are a variety of relationships tailored to the needs, resources, and opportunities available. In 1995, nearly 1,025 short-term, non-federal hospitals provided the training sites for over 88,000 residents and clinical fellows in graduate medical education programs. The Veterans Health Administration also supports almost 9,000 filled residency positions, or 8.7 percent of filled residency training positions in the United States.

Undergraduate Medical Education. Prior to residency training, medical students complete four years of medical school. The "hands-on" clinical education of medical students consists of clerkships in hospitals and other clinical settings during which medical students spend a fixed amount of time under the supervision of faculty and residents in various specialties. Residents contribute substantially to the education of medical students, and their presence is often critical to the success of undergraduate programs. In 1995, over 33,000 undergraduate medical students received clinical training at teaching hospitals or their affiliated educational sites.

Nursing and Allied Health Education. Hospitals also remain the primary sites for the clinical training of nurses and other allied health professionals. While classroom training for nurses is now more likely to take place in a college or university, nurses still receive the major portion of their clinical education in hospitals. More than 25 other training programs in allied health fields are widely supported by teaching hospitals, including programs for physical therapists, respiratory therapists, and emergency medical technicians.

Provision of an Environment for Clinical Research. The nation's teaching hospitals and medical schools are the backbone of innovation in American medicine because they provide the environment for the conduct of clinical research and the introduction of new life-saving drugs, devices, and procedures into clinical practice. What is now commonly accepted medical care, such as treatment of infectious disease, came from laboratory and clinical research in academic health centers. Open heart surgery and life-saving organ transplantation were pioneered at teaching hospitals. From the use of ether in performing

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'painless' surgery 150 years ago, to the development of neonatal intensive care units, and the promise of gene therapy in curing inherited genetic disease, medical schools and teaching hospitals serve as locations for experimentation and development of new knowledge that benefits the world. Many of these advances began in basic research laboratories of universities and their affiliated hospitals; most of the advances were transferred to patient care as clinical research programs at teaching hospitals. After rigorous evaluation in major medical centers, many of these innovations are adopted in other provider settings. Teaching hospitals offer a natural setting for the advancement and early application of medical knowledge by bringing together seriously ill patients and research-oriented faculty physicians.

Provision of Patient Care Services. In addition to their education and research missions, teaching hospitals are, first and foremost, providers of a broad range of health care services. They provide all levels of patient care--from preventive to tertiary services. They are local institutions providing basic hospital care in their neighborhoods and communities. They also are referral institutions providing tertiary care to statewide and regional populations, as well as community service institutions caring for patients from all economic and social backgrounds. Because of their research activities, teaching hospitals house the newest and most advanced services and facilities and with residents and supervising physicians available around-the-clock, teaching hospitals often care for the nation's sickest patients.

Why COTH Member Hospitals are Different

All teaching hospitals share three common objectives: education, research and patient care. However, while teaching and non-teaching hospitals operate in the same general organizational, social and financial environment, academic medical center hospitals, defined as short-term, nonfederal members of the AAMC's Council of Teaching Hospitals and Health Systems (COTH), have distinctive organizational and service characteristics. Membership in COTH requires hospitals to sponsor or participate in at least four approved residency programs and have a signed agreement with an accredited school of medicine. Thus, COTH member hospitals, which include 75 Veterans Affairs medical centers, are the backbone of graduate medical education, training about 75 percent of all residents in the U.S.

Comparing the 276 short-term general, non-federal members of COTH that reported data to the American Hospital Association in 1994 with the 828 other teaching hospitals and 3,853 non-teaching hospitals reveals striking differences about the characteristics of COTH members. Nearly two-thirds of COTH hospitals, but less than one-half of other teaching hospitals, are located in metropolitan areas of over one million population. In contrast, over one-half of non-teaching hospitals are located in rural areas. COTH hospitals are significantly larger than other hospitals. Over one-half of COTH hospitals have more than 500 beds; in comparison over one-half of non-teaching hospitals have under 100 beds. More than two-thirds of other teaching hospitals have between 100 and 400 beds. As large organizations with multiple responsibilities, COTH members also employ many personnel, often serving as economic engines in their local communities or regions. COTH members are primarily sponsored by non-profit organizations. About one-quarter are state university hospitals or major inner city municipal hospitals. Only three COTH members, or 1 percent, are investor-owned hospitals, while 7 percent of other teaching hospitals and 15 percent of non-teaching hospitals are owned by for-profit entities.

COTH members are major providers of patient care services and offer a wide range of hospital services. In 1994, while comprising only 6 percent of all hospitals, COTH members accounted for 20 percent of all admissions; 21 percent of all births; 23 percent of outpatient visits; and 18 percent of all surgeries performed in short-term, non-federal hospitals.

COTH members' unique responsibilities compel them to serve the needs of their communities differently than other teaching and non-teaching hospitals:

- Seventy-one percent of COTH members operate certified trauma centers, compared to only 29 percent of other teaching hospitals and 13 percent of non-teaching hospitals;
- Sixty-three percent of non-federal COTH members provide organ transplant surgical services compared to only 16 percent of other teaching hospitals and 3 percent of non-teaching hospitals;
- Ninety percent of all COTH hospitals provide both inpatient and outpatient AIDS services, while 69 percent of other teaching hospitals and only 33 percent of non-teaching hospitals provide similar services;
- Ninety-four percent of COTH members provide cardiac catheterization services compared to 68 percent of other teaching hospitals and 33 percent of non-teaching hospitals; and COTH hospitals provide similarly disproportionate amounts of open heart surgery and angioplasty services.

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Teaching hospitals provide a disproportionate share of health care services to the most disadvantaged members of our society. Non-federal COTH members have 18 percent of the nation's beds, but 24 percent of all Medicaid inpatient days. In addition, COTH members provide a disproportionate share of uncompensated care. In 1993, COTH members wrote off 45 percent of the charity care ($4.9 billion) incurred by non-federal hospitals, and 27 percent of all bad debt expense.

The Current Financing Structure of Teaching Hospitals and Medical Schools

It is important to understand that in academic health centers, patient care, research and education occur simultaneously. Patients may receive care for complex medical problems or diseases that require state-of-the-art treatment and in that role may become subjects of clinical research trials. At the same time, physicians educate and involve residents, medical students, and other health professionals in caring for patients, who may also be enrolled in clinical research protocols.

Providing an environment in which health professional education and clinical research can flourish adds to the cost of patient care services at teaching hospitals and medical schools. Both teaching hospitals and medical schools have traditionally relied on a complex and delicate web of clinical revenue support to finance their additional missions.

The Current Financing of Teaching Hospitals. Teaching hospitals have long relied on revenues from patient care to cover most of the costs of the many services or products they provide for society. Patient care dollars have enabled teaching hospitals to support specialized services that are particularly expensive but vital community and regional resources. Patient care revenues also help cover the cost of treating those who cannot pay for their care and the cost of training health professionals. Teaching hospitals traditionally have financed their education and research activities with revenues from patient care. However, in the newly price-competitive market, private insurance companies, businesses, and some government purchasers of health care want to pay the lowest possible price for only those services that their enrollees receive.

Teaching hospitals are experiencing increasing difficulty in maintaining their educational and other social missions, which add to their cost structures, because they must meet the price competition from nonteaching hospitals when negotiating with nongovernment managed care contractors. State Medicaid programs are retreating from making special payments to teaching hospitals for their education and other societal missions. In addition, state Medicaid programs are increasingly entering into risk-based contracts under which teaching hospitals are forced to be price competitive with nonteaching hospitals.

At present, only two purchasers of services--the Medicare program and, in many states, Medicaid programs--recognize the additional costs of teaching hospitals. Since the focus of this hearing is the Medicare program, I will not address in detail Medicaid's participation in GME financing, except to note that most state Medicaid programs, but by no means all, include payments under their fee-for-service systems for the equivalents of Medicare direct graduate medical education payments and Medicare indirect medical education payments.

The Direct Graduate Medical Education (DGME) Payment. The Medicare program makes explicit payments to teaching hospitals for the costs of physician clinical training through the direct graduate medical education (DGME) payment. These payments are for the added direct costs of physician training, including salaries and fringe benefits for trainees and the faculty who supervise them; classroom space; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (Senate Report, Number 404, Pt. 1, 89th Congress, 1st Sess. 36 (1965) and House Report, Number 213, 89th Congress, 1st Sess. 32 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and

Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals. If there was ever an assumption that the "community" would take responsibility for its share of these costs, it has not occurred in the past thirty years and seems even less likely to happen in the current competitive environment.

Medicare support of direct graduate medical education costs is not open-ended, but the program imposes no limit on the total number of residents it will support. Today, the Medicare program pays its proportionate share of a hospital-specific per resident amount based on audited costs from a 1984 or 1985 base year and updated for inflation rather than on the basis of DGME costs actually incurred. A hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital.

The Medicare program places limits on the number of resident trainee years for which full Medicare payment applies. Full support is restricted to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. Payments for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent. The five-year count is suspended, however, for a period of up to two years for training in a geriatric or preventive medicine residency or fellowship program.

The Indirect Medical Education (IME) Adjustment. Since the inception of the prospective payment system in 1983, the Medicare program also has made payments for the higher operating costs of teaching hospitals through the indirect medical education (IME) adjustment. While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

Thus, the IME adjustment is not to be confused with DGME payments, which are completely separate from the prospective payment system and serve a different purpose. It also should be noted that the Medicare program does not pay for a portion of the costs of clinical research or undergraduate medical education.

The Current Financing of Medical Schools. Medical schools support their education and research activities through tuition, endowment income and gifts, state appropriations, and federal and private grants and contracts. These are supplemented, however, by a complex system of clinical revenue support, primarily from faculty practice plan revenues.

Tuition and fees accounted for only 4 percent and state appropriations 10 percent of total medical school revenues in 1993-94. Faculty practice plan revenues represented 33 percent of total medical school revenue in that year; by contrast, in 1980-81, they contributed only 16 percent of the total. A portion of faculty practice plan revenue is used to cover the costs of uncompensated care. Faculty practice plan revenues also support academic programs in several ways. First, a portion is directly transferred to the medical school, its departments, and other research institutes and centers. This is discretionary money available to deans and department chairs to underwrite important teaching programs and a range of scholarly research activities. Second, the revenues are used to compensate clinical faculty for time spent in teaching and research. If clinical faculty were not engaged in these academic activities, their clinical productivity and the generation of patient care revenue would be far higher. Finally, some faculty

practice plan revenues provide direct support for residents and fellows, and indirect support for academic programs by paying the operating expenses of clinical practices in which these programs are intermingled.

The AAMC recently conducted a study, which estimated that a total of $2.4 billion of faculty practice revenue in 1992-93 was used to support academic programs. This represented 28 percent of the $8.3 billion of faculty practice revenue reported by U.S. medical schools that year. The academic program benefiting the most from faculty practice plan support was research, at an estimated level of $816 million. This amount is notable because it is a sum equivalent to one-fifth of the revenues medical schools received that year from the National Institutes of Health. While the division of this support between research in the basic or clinical sciences is not known, there is evidence to suggest that the bulk of the support was for clinical research and scholarly activities of the clinical faculty. Undergraduate medical education was the next largest beneficiary of faculty practice plan support, at $702 million, followed by graduate medical education at $394 million.

Research at academic health centers is supported by a variety of public, private, and institutional sources in addition to faculty practice plan revenues. The federal government, especially the National Institutes of Health, has been and remains the cornerstone of research support at academic health centers. However, institutional cost-sharing has been a growing factor in federally-sponsored research. Similarly, research sponsored by philanthropic and industrial sources rarely pays the full costs borne by the institution.

The shortfalls caused by uncompensated research costs are offset by significant institutional support, usually from funds derived from clinical practice. These funds also provide seed money for innovative faculty research projects prior to demonstration of their competitiveness for external funding, support for investigators during temporary periods in which funding is not available, information technology, renovation of research facilities, major research equipment, faculty recruitment, administrative compliance with state and federal regulations, and assorted overhead expenses not reimbursed through other mechanisms. In addition, the research environment reduces clinical productivity because research activities command faculty time that would otherwise be available for patient care. As more clinical research and care move from the inpatient to the outpatient settings, this problem will become more acute. To a large degree, clinical research in ambulatory settings is more complicated to accomplish.

The Future Financing of Teaching Hospitals and Medical Schools

As complex institutions with multiple and varied funding streams, teaching hospitals and medical schools are subject to many different environmental pressures, but their dependence on clinical revenue to support their education and research missions makes them extremely vulnerable to changes in the delivery system. The shift to a price-driven and more explicit financing system threatens the fragile nature of teaching hospitals and medical schools and their ability to fund research and education.

Academic medicine is adapting to a market-driven health care delivery system, but is concerned about proposals that would jeopardize its ability to fulfill its core missions. There are three fundamental principles which the AAMC believes should guide changes in the delivery system and the Medicare program:

Principle 1. The AAMC believes in a "shared responsibility" approach to financing the special missions of academic medicine. The AAMC has consistently supported a policy that graduate medical education and other societal missions are the shared responsibility of all entities that pay for hospital and health-related services on behalf of their enrollees. In September 1995 the AAMC endorsed the concept of a trust fund as a means of assisting teaching hospitals in meeting the special costs associated with their education mission.

This trust fund concept was part of H.R. 2491,, the Balanced Budget Act of 1995, as adopted by the U.S. House of Representatives on October 19, 11995 and by the U.S. Senate on October 28, 1995. This legislation would have created a Teaching Hospital and Graduate Medical Education (THGME) Trust Fund consisting of five separate and distinct accounts. Three of the five accounts would have been funded by appropriated general revenue, and the Medicare program would have contributed funds to the two other accounts. The AAMC believes that the creation of a trust fund is an important transition toward re-establishing the principle of shared responsibility and creating a societal approach to financing the societal missions of teaching hospitals in the new competitive delivery system.

Some policy makers believe that the creation of a trust fund would serve as replacement funding to ameliorate the impact of reductions in Medicare DGME and IME payments. However, the AAMC hopes that, to a significant degree, the creation of the trust fund, which includes non-Medicare revenue, can

be viewed as a transition toward establishing the principle of shared responsibility. We believe that the designated general revenue funds would have replaced in part the dollars which Medicaid and private payers have provided for these purposes traditionally through higher payments to teaching hospitals. A trust fund would create a framework for all parts of the health care delivery system to participate in the financing of clinical education. The Association is anxious to work with the members of this subcommittee to enact a trust fund for teaching hospitals.

The AAMC also notes that H.R. 2491, the Balanced Budget Act of 1995, included additional study of graduate medical education and its funding. Among the issues identified for further study was the "financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and the method of financing used for the MedicarePlus program." The legislation directed the Prospective Payment Assessment Commission (ProPAC) to study this issue in addition to federal policies on international medical graduates and the dependence of schools of medicine on service-generated income.

The AAMC believes that medical school dependence on clinical income is a particularly pressing issue. While current data from 1994-95 (forthcoming in JAMA) indicate that the majority of U.S. medical schools are performing increased volumes of clinical work, practice plan revenues on average are barely holding steady on a per clinical faculty member basis; for many schools this measure is declining. Schools have substantially expanded their clinical faculties to remain competitive and to maintain their market share, but it appears that reductions in units payments related to managed care and increased competition have put pressure on financial margins.

The Role of Medicare Managed Care in a Shared Responsibility Approach. The AAMC believes that the Medicare program should contribute to the mission-related activities of teaching hospitals on behalf of all its beneficiaries, both those who remain in traditional fee-for-service plans and those who opt to enroll in risk-based plans. Under the proposed trust fund, the Medicare program would have continued to make IME and DGME payments on behalf of its fee-for-service beneficiaries, but not on behalf of its enrollees in risk-based plans.

The AAMC believes that the Medicare program should contribute to a trust fund on behalf of its beneficiaries enrolled in risk-based plans. To do this, the methodology used to calculate the Adjusted Average Per Capita Cost (AAPCC), the rate that the Medicare program pays to its risk-based plans and that was not addressed in H.R. 2491, the Balanced Budget Act of 1995, should be modified. The AAMC believes that payments for DGME costs and for patient care costs attributable to the special roles of teaching hospitals (IME and DSH) should be preserved for their intended purposes. Modification of the AAPCC methodology is needed to ensure that the Medicare program meets its obligation for its beneficiaries in risk-based plans under the shared responsibility principle.

After considerable study, the AAMC has concluded that the current method of calculating the Medicare AAPCC results in a payment system that creates an uneven playing field between teaching and non-teaching hospitals. The AAPCC calculation incorporates all Medicare expenditures, including the DGME, IME and DSH payments. Once these payments have been included in the AAPCC and paid to a risk contractor, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with risk plans because the risk contractor receives the same AAPCC amount regardless of with whom the risk plan has a contract.

The AAMC recommends that both near-term actions to address the immediate issue at hand, as well as longer-term actions to resolve issues surrounding the current Medicare payment methodologies (DGME, IME, DSH, and AAPCC). In the long term, initiatives should be undertaken to identify and study potential alternative contracting mechanisms to the AAPCC methodology. For the near term, DGME, IME, and DSH payments should be removed prior to the calculation of the AAPCC rates and paid directly as intended by Congress to teaching and non-teaching DSH hospitals that incur the costs of these activities. These "carved-out" mission-related payments should be made to teaching institutions when Medicare risk contract enrollees utilize their services. The AAMC recommends that separate payment methodologies, which mirror the current Medicare regulations and are administratively feasible, be applied to each component of the DGME, IME and DSH payments. This approach could be accomplished through direct payments to the providers by continuing to use the current Medicare payment methodologies and settlement process with some relatively minor technical changes.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk-based plans grows. As Medicare beneficiaries increase

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their participation in managed care plans, or exercise other options, such as Medical Savings Accounts (MSAs) and fee-for-service payments decline, the mission-related dollars lost by teaching hospitals will increase substantially. Additionally, the same issues will arise under proposals to increase enrollment in Medicaid managed care programs. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding risk-based contracts among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Principle 2. The AAMC believes that teaching hospitals and teaching physicians should not bear more than their "fair share" of reductions in the rate of projected Medicare spending. The AAMC recognizes that unrestrained growth in Medicare spending threatens the long-term solvency of the Federal Hospital Insurance (HI) Trust Fund, and supports reforms to align trust fund income and outlays, but the proposed changes in the Medicare and Medicaid programs would have profound effects on the nation's health care system, and especially on teaching hospitals and medical schools. Teaching hospitals serve large numbers of the poor and elderly and depend heavily on Medicare payments for DGME, IME, and disproportionate share (DSH). Many teaching hospitals also serve large segments of the Medicaid population. For COTH members, Medicare and Medicaid payments on average constituted nearly one-half of all their net patient revenue in 1994. In the absence of a marketplace where all insurers or sponsors of patient care programs share responsibility for supporting the academic missions, these historical, explicit payments to teaching hospitals take on critical importance.

Any reductions proposed for DGME and IME payments are not reductions in the rate of increase of program spending, but are real cuts for teaching hospitals. Coupled with private sector losses, reductions in Medicaid spending and other cuts in projected Medicare payments, reductions in DGME and IME payments will force teaching hospitals to bear an unfair burden of Medicare payment reductions, making it more difficult for them to sustain their additional missions.

The Medicare Indirect Medical Education (IME) Adjustment. The AAMC believes that the IME adjustment should be maintained at a level that will allow teaching hospitals to fulfill their missions. As the Congress contemplates adjustments in the annual growth rate of the Medicare program, payments for hospital services are principal targets.

Proposals to slow the growth in PPS operating payments have centered on three specific elements: the annual increase in the basic PPS price for all hospitals, called the update factor, and two add-on payments, the IME and DSH adjustments. All hospitals' Medicare payments are affected by changes in the update factor, but only certain types of hospitals experience the effect of changes in IME and DSH payment policy. While teaching hospitals recognize the need to control Medicare expenditures to protect the long-term solvency of the program, these institutions would be affected not only by IME reductions, but also by reductions in the update factor and DSH payments. At the levels being proposed by some policy makers, these would be real cuts in payments that would endanger the ability of teaching hospitals to fulfill their core missions of patient care, education and research.

While policy makers regard the $4 billion in IME funds as a source from which to obtain budget savings, it must be remembered that IME payments, while a relatively small proportion of total Medicare spending, are absolutely vital to a relatively small number teaching hospitals. Work done by ProPAC has shown that IME funding is concentrated in relatively few teaching hospitals: about 140 teaching hospitals receive one-half of all IME payments. If the level of the IME adjustment is reduced, it would have a significant negative impact on the hospitals at the very high end of the continuum of teaching intensity.

Principle 3. Any changes in Medicare payment policy should be implemented gradually with an annual evaluation of their impact on the financial viability of different groups of hospitals. The AAMC believes that Congressional decisions on Medicare payment policies should be made in the context of their impact on the entire health care system. Non-federal COTH members account for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges. For many COTH member hospitals, Medicare payments comprise from one-quarter to one-third of all their revenue. Clearly, changes in Medicare payments will have a profound impact on these institutions.

The Financial Viability of Teaching Hospitals. In recent years, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care for all Americans.

Historically, teaching hospitals have had higher PPS inpatient operating margins--the excess or loss of

revenue attributable to PPS patients expressed as a percentage--on average than non-teaching hospitals, but teaching hospitals' total margins--the financial margins from all patients--have remained consistently lower than other hospitals' total margins. This relationship between PPS and total margins and teaching status persists in the most recent financial data available.

Recent Medicare IME payment policy has recognized the importance of IME payments to teaching hospitals' financial viability. In that regard, the AAMC believes that any changes in payment levels should be made gradually with periodic monitoring of their effect on the financial viability of teaching hospitals. Reductions in these payments could substantially harm the ability of teaching hospitals to fulfill their numerous and complex missions.

Proposals to Change the Size and Distribution of the Physician Work Force

For more than a decade, the AAMC has analyzed issues of physician work force supply and the mechanisms necessary to support the education of physicians. A review of the Association's efforts in this arena and our comments on the recommendations recently made by the Institute of Medicine (IOM) and the Pew Health Professions Commission were submitted in detail to this subcommittee on April 16, 1996. The AAMC endorses the recommendations set forth by the IOM Committee on U.S. Physician Supply, which are consistent with many of our current positions and activities. Both the AAMC and the IOM call for a closer alignment of the number of entry level residency positions with the number of U.S. medical school graduates. In addition, both organizations call for the development of funding mechanisms to assist hospitals that depend on residents who have graduated from non-U.S.-accredited medical schools to provide care to the poor in reconfiguring the delivery of health care.

The AAMC also agrees with a number of the recommendations made by the Pew Health Professions Commission. However, the Association takes strong exception to the Commission's recommendation that U.S. medical schools be closed to decrease enrollments by 20 to 25 percent. While the medical education system is indeed producing more physicians than are needed for the nation's medical care, data do not show that the number of U.S. medical school graduates entering residency training is excessive. With more than 25,000 entry-level residency positions and only some 17,000 U.S. medical school graduates, efforts should be made to reduce the number of first-year positions.

The American medical education system has developed an accreditation process for U.S. medical schools that requires vigorous peer review and continuous quality improvement. All accredited residency programs must meet the minimum standards established by the Accreditation Council for Graduate Medical Education (ACGME) and the specialty-specific Residency Review Committees (RRCs). While it is clear that improvements in the measurement of the quality of residency training are necessary, one measure of high quality might be programs that attract graduates of LCME- and AOA-accredited medical schools.

Reductions in the number of residency positions, or "right-sizing" the graduate medical education enterprise, should begin with those programs that do not attract graduates of U.S. medical schools. This process will require difficult decisions. Hospitals that cannot reduce positions due to service demands by the populations they serve must get adequate financial assistance to maintain their patient care mission. However, after the process is complete, the quality of graduate medical education training and the size and compositions of the physician work force will be better aligned.

Medicare Payments with an Educational Label. Proposals to reform Medicare DGME and IME payments have been stimulated by both the need to limit the growth in Medicare expenditures and the need for an appropriately-sized and -trained physician work force. Some proposals seek to achieve a more appropriately configured physician work force by shifting the balance of generalist and nongeneralist physicians, or placing limits on the total number of physicians-in training, or encouraging residency training in non-hospital settings. The AAMC offers three suggestions for changes in the Medicare program that would improve the educational environment for physicians.

1. The AAMC supports changes in Medicare DGME funding to encourage residency training in non-hospital, ambulatory sites, such as private physicians' offices, freestanding clinics, or nursing homes and believes that Medicare DGME payments should be made to the entity that incurs the cost. Current law regarding Medicare DGME payments explicitly states that DGME payments may be made only to hospitals. Recipients of payments could be teaching hospitals, medical schools, multi-specialty group practices or organizations, such as GME consortia, that incur training costs. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization in which the program functions must determine the institutional commitment to graduate medical education.

2. The AAMC believes that the current rules for counting residents for purposes of IME payments should be changed to remove barriers to training physicians in non-hospital, ambulatory settings. In making this change, the Congress could allow hospitals to count residents in non-hospital ambulatory training sites for purposes of calculating the resident-to-bed ratio in the payment formula, as long as the total number of residents counted by the hospital did not exceed the number it counts currently. Hospitals could be required to use the ratio in effect for the 1995-96 fiscal year.

3. The AAMC supports limiting Medicare DGME funding to graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). This change in Medicare funding must make provisions for appropriate transitional--and potentially permanent--mechanisms to address the impact on crucial patient care functions of hospitals that are adversely affected by a substantial reduction in the number of residents. Currently, Medicare provides support for medical school graduates regardless of whether they are graduates of U.S. or foreign medical schools. While the number of graduates of U.S. allopathic medical schools has remained relatively stable for several years, the number of IMGs receiving training in this country has increased substantially. Between 1988 and 1993, the number of IMGs in graduate medical education nearly doubled from approximately 12,000 to nearly 23,000. In 1993-94, nearly 27 percent of all first-year residency training slots in allopathic and osteopathic programs were filled by IMGs.

In response to concerns regarding overall physician supply, on June 22, 1995, the AAMC Executive Council adopted a policy position on the physician work force and the participation of IMGs in graduate medical education:

> That the Association of American Medical Colleges, in recognition of the growing oversupply of physicians in the United States, pursue and undertake initiatives to address the future supply of physicians consonant with legal restrictions and requirements. While the Association should consider all available options for addressing this oversupply, it should--first and foremost--pursue options to diminish the number of international medical graduates pursuing graduate medical education in the United States and remaining in the United States following the completion of their graduate training. Any options supported by the Association that would result in constraints on the number of international medical graduates receiving training must include mechanisms to mitigate the impact on hospitals that currently train IMGs and those hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for IMGs would cause substantial access and service problems for Medicare beneficiaries. One of the issues that policy makers would need to address in enacting such a change would be the implementation of a process and a time table so that patient access to services would not be reduced precipitously. Additionally, mechanisms would be needed to mitigate the impact on hospitals that currently train IMGs and on hospitals that are highly dependent on IMGs for maintenance of their patient care programs.

A variation of this proposal offered by some policy makers would limit Medicare DGME payments to a defined number of residents. One option could be to freeze the number of full-time equivalent (FTE) residents that the Medicare program would support at the current number of residents in the training system. A more aggressive option that has been suggested might be to impose an aggregate limit on the total number of positions, e.g., the number of U.S. graduates plus some add-on percentage for IMGs. It should be understood that these proposals could require the establishment of control or regulatory mechanisms.

Conclusion

The AAMC regrets that the possibility of establishing a "shared responsibility" fund for the special missions of teaching hospitals and medical schools apparently has been delayed. This approach to financing the special missions of academic medicine is an issue that continues to deserves the Subcommittee's attention. All evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

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Chairman THOMAS. Thank you very much, Mr. Goldfarb.
Mr. Brideau.

STATEMENT OF LEO P. BRIDEAU, GENERAL DIRECTOR AND CHIEF EXECUTIVE OFFICER, STRONG MEMORIAL HOSPITAL, ROCHESTER, NEW YORK, AND CHAIRMAN, BOARD OF TRUSTEES, HEALTHCARE ASSOCIATION OF NEW YORK STATE, ALBANY, NEW YORK

Mr. BRIDEAU. Thank you, Mr. Chairman and Members of the Committee, for the opportunity to speak with you on this very important matter. My name is Leo Brideau. I serve as the chief executive officer of Strong Memorial Hospital of the University of Rochester. It is its principal teaching hospital. I also chair the board of trustees of the Healthcare Association of New York State.

As the State that trains the largest number of physicians, New York certainly has a valuable perspective to bring on the topic of medical education. And before I begin, I want to thank you, Chairman Thomas and Ranking Member Stark for the attention you have paid to the very special circumstances of New York, and I do want to recognize also the fine work of Congressman Amo Houghton, who serves on this Subcommittee. He has earned the respect of all of us for his wisdom and integrity, as well as to acknowledge the work on the Ways and Means Committee of Congressman Rangel, whose leadership has meant better health care for all New Yorkers, and Congressman Mike McNulty, who also serves on the Ways and Means Committee.

What I would like to do is to begin by providing you with a brief synopsis of all that we do at Strong to underscore the enormous value of medical education as a key component of the service delivery of the region, and then comment on three areas: One being the appropriate role of government in medical education; second, the notion that we need to rely on the marketplace to adjust physician training and supply; and, finally, I want to talk about the value that international medical graduates bring to New York's health care system.

Strong Memorial is the largest acute care hospital in New York's third largest city, and we provide the tertiary set of services for Monroe County and the 10-county Finger Lakes region, which is largely a rural region, about 1.4 million people in total. In addition, we train 640 medical residents, over 150 fellows, and conduct about $100 million per year in sponsored research. We provide a good deal of the uncompensated care that is provided in Monroe County for a whole variety of services.

We serve as one of 30 bone marrow transplant centers nationwide and are designed as a Center of Excellence, one of 13 Spinal Cord Injury System hospitals.

We are one of only six sites nationally designated as an AIDS Vaccine Evaluation Unit and serve as a State-designated AIDS treatment center and are one of the eight Alzheimer's disease centers in New York and are the recipient of a Pepper Center grant.

In addition to those tertiary services, we also provide health care to a large rural population throughout the Finger Lakes region of New York.

Both directly and indirectly, Medicare contributes to our ability to fulfill our mission through these activities. And, we realize that you face a difficult task. The Medicare Hospital Trust Fund is spending more than is being collected, and there is a perception that Medicare pays more than its fair share of graduate medical education. That has prompted some policymakers to again suggest cutting what Medicare pays hospitals to treat Medicare patients. These proposals come at a time when our population is aging, has growing health care needs, and deserves improvement in the treatment of such debilitating diseases as Alzheimer's and others—improvement that will only come through rigorous biomedical research and through the educational program for physicians and allied health professionals that we depend on our academic medical centers to provide.

The Healthcare Association of New York State believes that any change in Medicare must be made within the context of the Nation's responsibility to both its current and its future elders. Viewed in that context, reform should be oriented to protecting the program's financial viability while preserving its goal of enhancing the quality of life for our senior citizens through the quality of health care. We should not only seek to moderate the program costs, but also expand options for service and align revenues with projected spending.

Consequently, cuts in Medicare indirect and direct medical education payments to hospitals should be minimized, and, furthermore, we believe that a trust fund should be established to provide non-Medicare support for financing medical education.

Investment in graduate medical education is an investment in improving the health of entire communities. Both public and private sources need to share in that investment. The funding base needs to be as broad as possible. We believe concentrating medical education in Centers of Excellence such as New York is a national benefit that should be financed as a national public good.

The Pew Health Commission's report, the subject of a prior Subcommittee meeting, calls for a broader sharing of costs of medical education, advocating the establishment of a private-public partnership for funding through insurance premiums.

At the same time, the report from the Institute of Medicine wisely recognizes the link between medical education and the provision of charity care for the poor and uninsured. It strongly recommends that State and Federal Governments take immediate steps to develop a mechanism to provide replacement funds as opposed to simply transition funds. Further, we also argue for the carve-out of the medical education funds from the AAPCC provided so it can go directly to those providing that education and not into the pockets of HMOs.

Finally, the notion of international medical graduates is one that I would like to address. It is one that really needs our attention because we simply can't solve the problems on the back of international medical graduates. They provide key services not only during the time that they are in training, but they also provide key services when they leave. And, I know in my region many of the rural hospitals' medical staffs are largely made up of these international medical graduates. If we don't have that pool of physi-

cians, we aren't able to staff those hospitals. That is not just an inner-city problem, though it is a serious inner-city problem.

Our view is that international medical graduates who pledge to serve in those regions that are underserved or serve in underserved disciplines should be permitted to stay in this country.

Mr. Chairman and members, I thank you for giving me the opportunity to speak today. The goal of reforming medical education should be one that is left to the system, to the marketplace, and, Congressman Stark, I agree with you that this is not an area that lends itself very well to dictating it through regulation.

Thank you.

[The prepared statement follows:]

STATEMENT OF LEO BRIDEAU
OF STRONG MEMORIAL HOSPITAL
AND HEALTHCARE ASSOCIATION OF NEW YORK STATE

Mr. Chairman and members of the House Subcommittee on Health, thank you for the opportunity to speak on this important matter. My name is Leo Brideau. In addition to being the Chief Executive Officer of Strong Memorial Hospital -- the 736-bed teaching hospital for the University of Rochester School of Medicine and Dentistry -- I chair the Board of Trustees of the Healthcare Association of New York State. I appear before you today with Daniel Sisto, President of the Healthcare Association of New York State.

As the state that trains the largest number of physicians, New York has a valuable perspective on medical education. New York States academic medical centers and teaching hospitals train approximately 15% of the nations future physicians.

Before beginning my testimony, I want to thank you Chairman Thomas and Ranking Member Stark for your recognition of New Yorks unique situation and for the attention you have paid to our special circumstances.

I also want to say that it is a pleasure to appear before one of my Western New York neighbors, Representative Amo Houghton who has been a tireless advocate for improving Medicare and the health care system. We are proud to have him represent our state.

I also would like to acknowledge Representative Charles Rangel of New York -- whose leadership on the Subcommittees parent Ways and Means Committee has improved health care for all New Yorkers -- and Representative Mike McNulty of New York who also sits on the Ways and Means Committee.

Lastly, I would like to acknowledge Representative Nancy Johnson who has worked tirelessly on graduate medical education issues. We appreciate her hard work and look forward to continuing to work with her.

I would like to begin by telling you a bit about what we do at Strong Memorial. Although our mix of services and programs is unique, Strong is *not* unique among teaching hospitals in having an integrated mission of care, education, and research. The opening sentence of our mission statement says it best: We improve health through caring, discovery, teaching and learning.

Strong Memorial is the largest acute care hospital in New Yorks third largest city and provides tertiary care for surrounding Monroe County and the rural Finger Lakes region to the south. All together, close to 1.4 million people depend on Strong Memorial for all or part of their care.

We provide $7 million a year in uncompensated care to persons with no or inadequate insurance and in unreimbursed services devoted to community health and wellness.

We are one of 30 bone marrow transplant centers nationwide to be designated a Center of Excellence by Blue Cross/Blue Shield and one of 13 Spinal Cord Injury System hospitals in the nation.

Along with the UCLA Medical Center, Mayo Foundation, and others, we formed the Academic Medical Center Consortium which is devoted to improving the quality, effectiveness, and outcomes of clinical practices while keeping costs to a minimum.

Since Monroe County has the highest cumulative number of reported AIDS cases in upstate New York, we serve as a state-designated AIDS Center. We also are one of only six sites nationally designated as a National Institutes of Health-sponsored AIDS Vaccine Evaluation Unit.

Strong Memorial also serves as a regional trauma center and are one of eight regional Alzheimers Disease Assistance Centers in New York.

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We have a partnership with St. James Mercy Hospital in Hornell and Jones Memorial Hospital in Wellsville -- two small communities to the south -- to enhance care in rural areas. With Wyoming County Community Hospital in Warsaw, New York, we operate a family health care center. And we help area hospitals recruit physicians trained at the University of Rochester for the primary, emergency, acute, and continuing care services that their communities need.

Both directly and indirectly, Medicare contributes to our ability to fulfill our mission through these activities. In other words, a lot of caring and curing rides on the decisions made by this Subcommittee regarding funding of graduate medical education.

GOVERNMENT HAS AN OBLIGATION
TO ENSURE THE TRAINING OF FUTURE PHYSICIANS

We realize that you face a difficult task. The recent Medicare Trustees report found that the Hospital Trust Fund is already spending more than is being collected in payroll taxes. In addition, there is a perception that Medicare pays more than its fair share of graduate medical education costs. This situation has prompted some policymakers to once again suggest cutting what Medicare pays hospitals to treat Medicare patients and, specifically, reducing Medicare funds for graduate medical education. But that is a short-term solution at best.

The level of reduction in the rate of growth considered during the 104th Congress was greater than that necessary to either preserve the solvency of the Medicare Hospital Trust Fund or balance the federal budget. It would have reduced Medicare spending too steeply at a time when our population is aging and not only has increasing health care needs, but also deserves improvements in treatment of such debilitating diseases as Alzheimers. These improvements will only come from rigorous biomedical research and will only be made available through the education of physicians and allied health professionals.

The Healthcare Association of New York State believes that any change in Medicare must be made within the context of the nations responsibility to both its current ***and future*** elders. Viewed in that context, reform should be oriented to protecting the programs financial viability while preserving its goal of enhancing the quality of life of seniors by ensuring their access to quality health care. Such reform requires a multi-faceted approach that not only seeks to moderate program costs, but also expands options for service delivery and aligns revenues with projected spending.

Investment in graduate medical education is an investment in improving the health of communities, and both public and private sources should share in that investment. This is an approach we have advocated in New York, and it should be adopted on the national level, as well. If you believe that Medicare is paying more than its fair share for medical education, the answer isnt cutting Medicare, it is requiring others who benefit from the improvements in health that derive from medical education to share in the cost.

The Pew Health Professions Commission report appropriately calls for a broader sharing of the costs of medical education, advocating the establishment of a public-private pool for funding health professions education that is tied to all insurance premiums.

In short, cuts in Medicare indirect and direct medical education (IME and DME) payments to hospitals should be minimized. Also, a trust fund should be established to provide non-Medicare support for financing medical education -- as an addition to, not a replacement for, Medicare funding. Some features of the GME trust fund proposed in the Balanced Budget Act should be incorporated into future budget legislation.

We also strongly support carving out funds for graduate medical education and disproportionate share hospital payments from Medicare managed care rates. These funds should go directly to the hospitals that train physicians and treat uninsured patients, with none being used for deficit reduction.

WE SHOULD RELY ON THE MARKETPLACE TO ADJUST PHYSICIAN TRAINING AND SUPPLY

The reports of the Institute of Medicine (IOM) and the Pew Health Professions Commission regarding medical education and physician supply -- the focus of a prior Subcommittee hearing -- make a substantial contribution to discussions of medical education reform.

The IOM would place greater reliance on market forces than on regulatory approaches to reduce the number of students entering the health professions and to encourage generalist rather than specialist training. This is the right approach. The power of the market to encourage such corrections is underscored by the results of the 1995 and 1996 National Resident Matching Programs. In both years, more than half of U.S. medical school graduates chose training in one of the generalist disciplines. Steep declines were recorded in several specialties; for example, there was a 53.8% reduction in the number of graduates choosing anesthesiology training and a 20.3% decline in the number choosing diagnostic radiology residencies. The experience in New York mirrors this trend. Moreover, the percentages of New Yorks medical residents in primary care and other generalist areas exceed the national averages.

Furthermore, many of New Yorks teaching hospitals are responding to the market by adjusting their curricula, training sites, and student mix. It is crucial to keep in mind that although the current demand for specialty physicians is declining, the demand for generalist physicians and for certain allied health professionals is rising and that this demand trend will continue as the Baby Boomers age -- suggesting a need for more training in geriatrics -- and as managed care gains in popularity and enrollment -- suggesting a need for more primary care practitioners. Relying on regulation rather than the marketplace to adjust the supply of health professionals could result in a future undersupply of needed professionals.

At Strong Memorial, we are responding to these trends with a number of ongoing adjustments in our health education programs. Ive already mentioned our focus on Alzheimers research and treatment. In addition, Strong and the University of Rochester have developed a masters level nurse-midwifery education program. With Ithaca College, we train much needed physical therapists.

In physician training, in 1993, we began a residency program in emergency medicine -- an area where there continues to be strong need. Overall, an increasing proportion of our medical students clinical experience occurs outside the hospital. In 1993-94, two-thirds of our third-year class spent half of their medical clerkship in practice-based settings, both in Rochester and in 10 small communities across New York State.

We are not alone in undertaking such initiatives. For example:

> Albany Medical College has made primary care dominant in their graduate medical education program. Their residents rotate to health maintenance organizations, group practices, and family practice centers.
>
> Bassett Health Care in Cooperstown has a residency training program in rural primary care. Program participants do a substantial amount of their training in rural community primary care clinics.
>
> The State University of New York at Buffalo has developed a nationally recognized medical education consortia that gives students a wide range of experiences in treating patients in a variety of non-hospital settings.

With regard to physician supply and distribution, the IOMs recommendations are preferable to those of the Pew Commission. While Pew recommends closing and downsizing health profession training programs, the IOM makes the more cautious recommendation that no new medical schools be opened or expanded. Caution is well-advised given the difficulty of predicting what ailments and diseases may afflict our population in the future, as well as the difficulty of predicting improvements in medical treatment and practice patterns.

If legislative and regulatory steps to reduce the supply of physicians are taken, please be cautious not to underestimate the future demand for physicians or other health professionals.

Also, please heed the Institute of Medicines wise recognition of the link between medical education and the provision of charity care for the poor and uninsured. The IOM report strongly recommends that the state and federal governments take immediate steps to develop a mechanism to provide *replacement* funds to those hospitals that depend on medical residents for provision of care to the poor, and it underscores the difference between replacement funds, which are ongoing, and transition funds, which are time-limited. Reducing teaching support, without providing adequate replacement funding, would jeopardize our teaching hospitals ability to provide care to the poor and uninsured.

Medical residents provide valuable services in the communities where they train and contribute to New Yorks status as a leading international center of medical advancement and research. Concentrating graduate medical education in centers of excellence, such as New York, is a national benefit that makes both financial and programmatic sense and should continue to be financed as a national public good. For example, this system has enabled six states (plus two Canadian provinces and two Canadian territories)* to forego the creation of academic medical centers while benefitting from the ability to obtain well-trained physicians to meet their needs.

THE VALUE OF INTERNATIONAL MEDICAL GRADUATES MUST BE ACKNOWLEDGED

One of the most troubling proposals floated in the halls of Congress would reduce physician supply by limiting or eliminating residency funding for international medical graduates (IMGs). Both the Pew and IOM reports attribute the overall oversupply of physicians in the United States to the growth in the number of IMGs, and both call for changes in federal funding of IMGs and tighter immigration laws to ensure that non-citizens return to their home nations upon completion of their training.

We believe that assisting the medical education of citizens of other nations is important for world public health and is an appropriate role for the United States as the leader of the free world. Apparently House Speaker Newt Gingrich feels similarly, because in a January 1995 speech before the American Hospital Association, Speaker Gingrich suggested that we measure the total number of specialists against world demand, not against American demand.

Strong Memorial is not a high IMG hospital, but I cannot emphasize enough the importance of IMGs to the health care of the communities that we serve. IMGs benefit our communities both during training and after entering practice. For example, after caring for New Yorks low-income residents during training, many of the IMGs who remain in the United States practice medicine in otherwise under-served communities. This is certainly true in the rural communities with which Strong Memorial is familiar.

The Healthcare Association of New York State believes that the same mix of public and private financing should be provided for the medical education of IMGs in recognition of the benefits they provide in our communities during training. We also believe that those IMGs who agree to

As many members of this Subcommittee observed during your April hearing on graduate medical education, if the supply of these physicians is cut, there is no mechanism to replace this talent in countless urban and rural communities across the United States.

In summary, the goal of reforming medical education should be to achieve a system that is responsive to the marketplace. The goal of reforming Medicares role in medical education should be to achieve a system that is responsive to the current and future needs of Medicare beneficiaries. Unfortunately, the proposals under consideration as part of the Balanced Budget debate would set up a future crisis. Our parents -- and, ultimately, we -- deserve better. Thank you.

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* Alaska, Delaware, Idaho, Maine, Montana, and Wyoming in the United States. New Brunswick, Northwest Territories, Prince Edward Island, and Yukon Territory in Canada.

enter a medical field that is under-supplied or who agree to practice in medically under-served communities should be allowed to remain in the U.S.

Chairman THOMAS. Thank you.
Dr. Wickless.

STATEMENT OF LARRY WICKLESS, D.O., VICE CHAIR, COUNCIL ON FEDERAL HEALTH PROGRAMS, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. WICKLESS. Thank you. Chairman Thomas and Members of the Subcommittee, thank you for inviting me to appear before you this afternoon. My name is Larry Wickless, D.O., and I appear today on behalf of the American Osteopathic Association.

For the record, my testimony has been endorsed by the American Association of Colleges of Osteopathic Medicine and the American Osteopathic Health Care Association.

Mr. Chairman, you stated last year that it is your intention to develop a policy which will encourage a better balance of generalists and specialists for our health care work force. I want to emphasize it is the osteopathic profession which, for the past century, has produced a work force in which primary and nonprimary care specialists are balanced in a way that more properly reflects the needs of our society. As a matter of fact, in your State alone there currently exists 154 osteopathic postgraduate training positions, including internships and residencies, positions which produce many of the physicians on which the citizens of the great State of California depend.

As is evident, we have a considerable amount at stake in how the Nation's GME system is reformed. The following are the AOA's recommendations:

First, the AOA believes that the Medicare beneficiaries directly benefit from GME and, therefore, because Medicare is a Federal program, the Federal Government should continue to be a major stakeholder in GME, but not the sole stakeholder. There are others who benefit from GME programs who need to step up to the plate, such as private insurers, pharmaceutical houses, medical equipment manufacturers, to name but a few.

The AOA also strongly supports the establishment of a national GME fund to which those who benefit from the GME would contribute. Once it is agreed that there should be multiple contributors to GME, there should exist standard payment principles under which all would have to abide.

Second, the AOA urges that the current DME payment methodology, which is based on hospital-reported costs in 1984, be revisited. The AOA strongly encourages the Subcommittee to establish a new reimbursement structure for the reimbursement of direct costs based on a national per-resident average. This would finally put all medical residents on a level playingfield.

Third, under current law, residents are counted as 1.0 full-time equivalents only up to the lesser of reaching initial board eligibility or 5 years. If the resident chooses to pursue additional subspecialty training, such a resident is counted as a 0.50 FTE. The AOA supports the current 50 percent rule.

Fourth, the AOA generally agrees with the Pew Commission's recommendation to reduce the number of GME training positions to the number of U.S. medical school graduates plus 10 percent. Any such methodology must specify that the number of funded

allopathic residency programs would be determined based on the number of graduates of allopathic schools, while the number of funded osteopathic programs, both internships and residencies, would be determined based on the number of graduates from osteopathic schools. This position has also been endorsed by COGME.

Fifth, the AOA supports a policy of gradually reducing the funds available for the training of international medical graduates to 25 percent of current levels. This position has also been supported by COGME.

Sixth, the current indirect medical education formula which is based on a training program's resident-to-hospital-bed ratio is unacceptable. The AOA believes that training in ambulatory settings must be specifically encouraged through any new IME reimbursement formula. The underlying concept is for training funds to be permitted to follow the resident and not for the resident to be constrained to follow the training funds.

Seventh, another of the Pew Commission recommendations is to redirect graduate medical education so that a minimum of 50 percent of the training programs are in primary care by the year 2000. We agree with this ratio. We point with pride to our history of meeting and even exceeding the primary care specialty ratio that has been identified as a national work force target. In fact, the College of Osteopathic Medicine of the Pacific, our osteopathic medical school in California, was recently ranked number one in the Nation among all medical schools according to the percentage of its physicians graduating in family practice and number three in the Nation by the percentage of graduates entering careers in primary care.

Eighth, the AOA also strongly encourages Federal support of educational consortia in graduate medical education. The AOA's accrediting program requires that by mid-1999 all osteopathic graduate medical education will be completed in osteopathic postdoctoral training institutions, OPTIs, comprised of at least one hospital and one osteopathic medical school. Integration of medical schools in graduate medical education will result in an integrated or seamless curriculum.

In conclusion, Mr. Chairman, thank you for hosting this important hearing here today. The AOA believes that only with the implementation of the aforementioned recommendations will we begin to prepare our Nation resident physicians and training sites for the next century in delivering quality health care for the public good, while generating significant savings in the Medicare Program.

Thank you.

[The prepared statement follows:]

STATEMENT OF
LARRY WICKLESS, D.O.
AMERICAN OSTEOPATHIC ASSOCIATION

Chairman Thomas and members of tthe Subcommittee, thank you for inviting me to appear before you this afternoon. My name is Learry Wickless, D.O., and I am the Vice Chair of the American Osteopathic Association's Councilil on Federal Health Programs. For nearly thirty years I have practiced osteopathic medicine, and am currently the Program Director for Gastroenterology at Botsford General Hospital in Farmington Hills, Michigan. The AOA recognizes that reform of the Nation's graduate medical education finaancing and workforce policies is a bold task. Based on the latest figures from the Medicare Trustees' Report, it is clear that some difficult decisions will have to be made immediately to ensure the solvency of the trust fund, and some of these decisions will have to focus on GME. Mr. Chairman, , by providing this opportunity to discuss the extent to which these decisions will impact the system under which our Nations' medical residents are trained, you are demonstrating tremendous leadership. I am honored to have been called on to help the Subcommittee begin to identify a workable ssolution.

OSTEOPATHIC MEDICINE

Inviting me to testify before you todaay is certainly reflective of your appreciation that there are two separate and distinct branches of meddical practice in the United States today -- osteopathic medicine and allopathic medicine. As you know, the majority of physicians in the country are allopathic physicians (M.D.s); however, osteopathic physicians (D.O.s) constitute more than five percent of all physicians practicing in the United States - almost 40,000 strong. However, osteopathic physicians represent more than 115 percent of all physicians practicing in communities of less than 10,000 people, and fully 18 perccent of all physicians serving communities of 2,500 or less. Further, osteopathic physicians providde care to patients in all private health systems as well as public programs, such as the military, IPublic Health Service, Veterans Administration, and Medicare and Medicaid. The D.O. and M.D. cdegrees are the only recognized degrees leading to the unlimited licensure for the practice of completee medicine and surgery.

Osteopathic medical practice grew out t of a concept developed over 120 years ago by Andrew Taylor Still, M.D. Dr. Still studied the attributes of good health so that he could better understand the process of disease. This ultimately lead tto a philosophy of medical care, focusing on wellness, preventive medicine, and the ability of the bbody to regulate its own health, which emphasizes the unity of all the body parts as a key element of fhealth. This philosophy is reflected in the osteopathic educational continuum, which has consistentlyy produced more than 60 percent osteopathic primary care physicians who provide a complete rangee of services to patients of all ages. The success of the osteopathic profession in producing communnity-level primary care medical practices is the result of the profession's carefully crafted educatiioonal continuum that emphasizes primary care and the osteopathic philosophy throughout all levels cof education and training. This continuum begins with four years of medical training, during which costeopathic medical students complete a curriculum of basic sciences and clinical studies, includingg the same subject matter taught in allopathic medical schools. In addition, osteopathic medical smudents receive training in the administration of manual medicine and complete significant course work in osteopathic principles and practice. This predoctoral program is followed by a unique costeopathic postdoctoral educational track. As I hope will be made clear upon the conclusion of myy remarks, it is this continuum that must be preserved, and strengthened, for our profession to helpp the nation's health care delivery system produce the appropriate mix and distribution of physicianns most in demand for the next century.

THE OSTEOPATHIC POSTDOCTORAIL EXPERIENCE

Following graduation from one of thee Nation's 17 osteopathic medical schools (in 1995 an estimated total of 1,843 graduated from theese schools), osteopathic physicians generally embark on a course of unique graduate medical educatiion. This postdoctoral training system is designed to build upon concepts taught during medical i school. Entry into an osteopathic residency training program is contingent upon completion of a onne-year internship. This internship includes mandatory rotations in the primary care areas of familyy practice, internal medicine, general pediatrics, and

obstetrics and gynecology, in addition to exposure in general surgery. This experience ensures that all osteopathic physicians are trained as primary care physicians first, even if they choose to specialize later in their careers in one of over 40 medical specialties and subspecialties. The osteopathic residency training curriculum includes the "utilization of osteopathic principles and practices relating to the specialty." This ensures that the concepts of osteopathic medicine continue to be cultivated following graduation from osteopathic medical school.

Mr. Chairman, you stated last year that "there is a growing consensus that the Nation needs more primary care physicians and fewer specialists," and that it was your intention to "develop a policy which will encourage a better balance of generalists and specialists for our health care workforce." As the Subcommittee continues to pursue the means to such an end, I want to emphasize that it is the osteopathic profession which for the past century has produced a workforce in which primary and non-primary specialties are balanced in a way that more properly reflects the needs of our society. As a matter of fact, in your state alone, there currently exist 154 osteopathic postgraduate training positions (including internships and residencies) - positions which produce many of the physicians on which the citizens of the great State of California depend.

My testimony today will concentrate on the recent graduate medical education recommendations of the Pew Health Professions Commission and the Institute of Medicine. As appropriate, I will include in my responses some specific recommendations on how to structure a more cohesive graduate medical education financing system that responds to the needs of both physicians and their patients.

As a clarifying note, all references in my statement to "physicians" and "medical schools" implies both osteopathic and allopathic physicians and both osteopathic and allopathic schools, as defined under existing Federal law.

CONTINUED FEDERAL PARTICIPATION IN FINANCING OF GME

In defining the parameters of the GME financing and resultant manpower debate, I believe that we must first decide on whether the Federal government should continue to have a role in the financing of GME. Since the advent of the Medicare Program, the government has channeled its GME monies through the Medicare service dollars and has been almost the sole financier of such programs. The AOA believes that Medicare beneficiaries directly benefit from GME and therefore because Medicare is a federal program, the federal government should continue to be a major stakeholder in GME ....., but not the sole stakeholder. There are others who benefit from GME programs who need to step up to the plate such as private insurers, pharmaceutical houses, and medical equipment manufacturers, to name a few.

Once it is agreed that there should be multiple contributors to GME, there should exist standard payment principles under which all would have to abide.

CONTROLLING THE NUMBER OF FUNDED GME POSITIONS

This past April, this Subcommittee heard several recommendations on how to revitalize the health professions for the 21st century from the Pew Health Professions Commission and the Institute of Medicine. The Institute of Medicine recommended bringing support for the total number of first year residency slots much closer to the current number of graduates of U.S. medical schools. The Pew Commission's recommendation in this regard was to reduce the number of funded graduate medical training positions to approximately the number of U.S. medical school graduates, plus 10 percent. The AOA generally agrees with this recommendation, but we do have some concerns about how such a methodology will be implemented. Because osteopathic and allopathic residency training programs are operated under separate jurisdictions, any such methodology must specify that the number of funded allopathic residency programs would be determined based on the number of graduates of allopathic schools, while the number of funded osteopathic programs (both internships and residencies) would be determined based on the number of graduates from osteopathic schools. This position also has been endorsed by COGME.

As you know, the Federal government is now funding the equivalent of 140 percent of medical school graduates. Recognizing that the proposed 110 percent would allow for a 10 percent adjustment for international medical graduate slots, the intent of this proposal is two-fold: 1) to gradually reduce the number of Federally-assisted training positions; and 2) to exact greater control over the number of international medical graduates training in the U.S. If appropriately implemented, this new methodology would still offer U.S. medical school graduates the opportunity to secure training positions. The positions available for international medical graduates, however, would be gradually phased-down. However, this represents only half of the international medical graduate issue. Without appropriate reimbursement policy changes to complement this new methodology, its effect might not completely respond to the needs of graduating physicians.

Last year, as you will recall, this Subcommittee's graduate medical education reform proposal included a provision early on which would have gradually phased-out the funds available for non-U.S. citizens to train in the United States. Through changes in the direct medical education (DME) funding stream, reimbursement to teaching hospitals for the direct training of non-U.S. citizens would have been phased-out by Fiscal Year 1999. While there is the potential for some unintended consequences associated with a complete phase-out of funds for training international medical graduates (most notably the access to care in many of the Nation's rural and underserved areas most often served by international medical graduates), the AOA supports the policy of gradually reducing the funds available for their training to 25 percent of current levels. This position has also been endorsed by the Council on Graduate Medical Education.

You will recall that Congress, through this Subcommittee, last year proposed a similar policy to reduce the number of training positions. But rather than apply the 110 percent methodology, the proposal was to freeze the number of residency positions in a teaching facility based on the number of positions as of August, 1995. This freeze would have been intact for seven years. The AOA appreciates the Subcommittee's efforts in this regard, but would like to propose clarifying language should this proposal be revisited this year. The legislation did not specify whether the freeze would be applicable to "approved" positions or "filled" positions. The AOA strongly urges the Subcommittee to clarify that such a freeze would be applicable to "approved" positions. Under such a freeze, residency programs must be afforded the opportunity to fill those positions which have already been approved for funding, and not be constrained to operate under the number of those positions that just happened to be "filled" on a specific date. Without this clarification, there will be no margin in the policy to allow for fluctuations in residency assignments. Demand for different programs changes over time and the funding mechanism should be sufficiently flexible to allow for funding more positions in programs where more positions are required.

Another of the commission's recommendations is to redirect graduate medical education so that a minimum of 50 percent of the training programs are in the primary care areas by the year 2000. As was mentioned before, the osteopathic profession has always graduated a majority of its physicians into primary care areas of practice. We agree that there is a shortage of primary care physicians in practice today, and we point with pride to our history of meeting, and even exceeding, the primary care-specialty ratio that has been identified as a national workforce target. However, our profession can only survive if our training programs receive an appropriate proportion of available funds. We must be able to maintain our distinct educational program beyond the medical school level. The simple fact is that osteopathic education requires more than the medical school experience; complete training in the osteopathic approach to medical care requires continued application of osteopathic principles and procedures in osteopathic postdoctoral training programs.

Another central feature of this Subcommittee's graduate medical education proposal last year was to reduce the funds available for residents who have achieved their initial board-certification. Under current law, residents are counted as 1.0 full time equivalents (FTE) only up to the lesser of reaching initial board certification or five years. If the resident chooses to pursue additional subspecialty training, such a resident is counted as .50 FTE. Under your proposal last year, a resident who pursues additional training past their initial board certification would be counted as .25 FTE. It is clear that the intent of Congress in this regard was to create a disincentive for physicians

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to train in subspecialties, or to force subspecialty training programs to re-engineer their curricula to be completed in five years or less. However, the question that needs to be asked is "Why cut the DME reimbursement level by another 25 percent over how much it was cut three years ago?" Recognizing that the current 50 percent payment rule was implemented just three years ago, it seems premature to cut it another 25 percent without having the opportunity to gauge the effects of the most recent set of cuts. The AOA supports the current 50 percent rule. Despite its negative impact on all subspecialties the AOA strongly encourages Congress to maintain that current level of reimbursement until such time that reliable data becomes available regarding the effect of the 1993 cuts.

ASSOCIATED REIMBURSEMENT ISSUES

As was alluded to previously, the AOA strongly urges the Subcommittee to revisit the current DME payment methodology which is based on hospitals' reported costs in 1984. This outdated system is nonresponsive and unappreciative of the current physician training climate. For the osteopathic profession specifically, the problems with the 1984 base year are further compounded. In the past, osteopathic graduate medical education was completed in osteopathic hospitals with a largely volunteer faculty, thus causing the "reported costs" of the training institution to be unrealistically low. In order to provide a more responsive and equitable payment methodology for the reimbursement of facilities' direct costs, the AOA strongly encourages the Subcommittee to establish a new reimbursement structure based on a National, per-resident average. Such a system could take into consideration necessary geographic adjustments without skewing its design. This proposal is not unique, as several legislative incarnations of GME reform over the years have included this policy recommendation. This would finally put all medical residents on a level playing field. As reflected in the Subcommittee's graduate medical education reform proposal last year, positive steps were taken to respond to these concerns, in that the historic payment method was replaced by updating the base year. However, several training programs which are training those physicians who are needed most in today's health care delivery system are still left at a significant disadvantage because the underlying reimbursement concept remains.

The indirect medical education (IME) funding is also flawed in that it does not take into account the importance of training residents in ambulatory care settings, and this system of training is one recommended most recently by the Pew Commission. The current formula is based on a training program's resident-to-hospital bed ratio. Maintaining this formula is a disincentive to moving graduate medical education to ambulatory clinics, community health centers, and managed care organizations. Larger academic health centers have the resources to maintain these ratios at a much higher level than their smaller osteopathic counterparts. Continuing to link IME payments to the resident-to-hospital bed ratio provides incentives to add residents based on hospital service needs rather than societal needs. The Subcommittee, in part, addressed this issue by establishing a formula based on hospitals' costs in a more recent base year. But the AOA strongly believes that training in ambulatory settings must be specifically encouraged through any new reimbursement formula. The underlying concept is for training funds to be permitted to follow the resident, and not for the resident to be constrained to follow the training funds.

The AOA also strongly supports the establishment of a National GME fund, to which all third party payers would contribute. Managed care capitation payments for Medicare are based on 95 percent of the average per capita rate of all Medicare costs, including costs for graduate medical education. Yet, most managed care entities do not incur any such costs. Private payers benefit from the graduate medical education system, and should contribute their fair share of the costs. An all-payer pool would ensure more stable funds for graduate medical education and, concurrently, realize significant savings for Medicare.

CONSORTIA MODEL FOR GRADUATE MEDICAL EDUCATION

The AOA strongly encourages Federal support of educational consortia in graduate medical education. In the Subcommittee's graduate medical education reform proposal last year, the Secretary of Health and Human Services was granted authority to fund such consortia for the purposes of training of residents. The AOA supports this provision. As was mentioned previously,

the old picture of osteopathic graduate medical education is changing. The AOA's accreditation program requires that by mid-1999, all osteopathic graduate medical education will be completed in Osteopathic Postdoctoral Training Institutions (OPTIs), comprised of at least one hospital and one osteopathic medical school. The new program will offer high quality postdoctoral training with the added resources of the osteopathic medical school. Integration of the medical schools into graduate medical education will result in an integrated or seamless curriculum. This concept will also allow some of the Nation's smaller rural hospitals to retain some role in training osteopathic physicians. This is significant recognizing that the physicians training in these smaller hospitals are more inclined to practice in the primary care disciplines. By becoming part of a consortium of training institutions that includes a large hospital, the osteopathic medical school, and some specialty hospitals, the small rural hospital can continue to have access to residents and their services. And the link between the medical school and the training sites under this OPTI structure will allow for the reinforcement of academic and didactic enhancements and osteopathic principles and practice, and their continued integration into a student's entire medical education and training.

ADVISORY PANEL ON GRADUATE MEDICAL EDUCATION

Mr. Chairman, I have identified several recommendations for reforming graduate medical education including changes in the reimbursement formulae, workforce recommendations, and ideal sites where training should be hosted. The issue of graduate medical education reform is complex, as you know having hosted this -- your third -- graduate medical education hearing in the 104th Congress. This is why it is imperative that your proposal from last year to establish a National Advisory Panel on Graduate Medical Education and Teaching Hospitals be reintroduced. Recognizing that osteopathic and allopathic graduate medical education systems are governed separately, it is equally important to have the AOA Council on Postdoctoral Training represented on any such panel. It is critical that experts in the field develop recommendations on whether and to what extent Federal policies regarding graduate medical education should be reformed.

CONCLUSION

In conclusion, the AOA believes that before any new payment methodologies are implemented, it must be decided who will be the payers of GME. These payors, who should include the Federal government, but not be limited to it, should agree on a standard set of financing methodologies which would include: 1) a policy under which the number of funded GME training positions would be based on the number of medical school graduates, plus 10 percent (this cap would be applied separately to graduates of osteopathic and allopathic medical schools), 2) a phase down of reimbursement for IMGS, 3) reimbursement for residents which would be based on a national per resident average, and, 4) dollars should follow the training, wherever it might occur.

In terms of program changes, the AOA strongly believes that GME should occur in consortia and that there needs to be an Advisory Panel on GME so that all the players and payors will have financing and program oversight responsibilities and opportunities.

Mr. Chairman, thank you for hosting this important hearing today. The AOA believes that only with the implementation of the aforementioned recommendations will we begin to prepare our Nation's resident physicians and training sites for the next century in delivering quality health care for the public good, while generating significant savings in the Medicare program.

Chairman THOMAS. Thank you.
Dr. Foreman, tell us about New York City.

STATEMENT OF SPENCER FOREMAN, M.D., PRESIDENT, MONTEFIORE MEDICAL CENTER, BRONX, NEW YORK, ON BEHALF OF GREATER NEW YORK HOSPITAL ASSOCIATION, NEW YORK, NEW YORK

Dr. FOREMAN. Thank you, Mr. Chairman. My written testimony addresses a number of issues concerning Medicare financing for graduate medical education, but I will focus my remarks mainly on international medical graduates.

Recently, interest has focused on ways to control the number of international medical graduates entering graduate medical education as a means of controlling the perceived national physician surplus, because many international medical graduates remain in the United States to practice after they complete their training. Though residents enter graduate medical education primarily to advance their own knowledge and skills, even while in training they are an extremely important part of the health care ecology, and they play a pivotal role in helping the hospitals in which they train meet the health needs of those communities. Nowhere is this more true than in hospitals in inner-city neighborhoods, neighborhoods which in general have not yet benefited from the Nation's growing supply of physicians.

New York City still has 125 federally designated health professional shortage areas. Graduate medical education programs often provide the only guarantee that individuals and families living in those communities have access to basic health care.

We know this Subcommittee has been concerned about the number of international medical graduates in the past and that New York accounts for a large proportion of them. In fact, 50 percent of all training positions in the New York City area are occupied by international medical graduates. And, nearly one-third of New York's 800 programs have 100 percent of their positions filled by international medical graduates.

Of particular importance is that these positions are concentrated in hospitals serving substantially poor populations. None are in academic medical centers.

We urge the Subcommittee to recognize that restrictions on international medical graduates will have a devastating effect on communities which have the greatest need for physicians since their hospitals which rely on IMGs lack the resources to replace their services. We urge Congress to move cautiously in formulating policies that will have a disproportionate impact on some of our Nation's most essential and most vulnerable hospitals and that substitute funding be made available for any reductions which are made.

Before closing, Mr. Chairman, I would like to offer two other recommendations. First, we urge Congress to maintain its commitment to graduate medical education not only for fee-for-service payments but for Medicare managed care. Health maintenance organizations now receive capitation fees which roll up Medicare payments for graduate medical education and disproportionate share adjustments into a single payment. There is no Federal require-

ment under current law that HMOs pass either of these public benefits payments on to the hospitals which provide the services or incur the costs. We urge Congress to enact provisions that would carve out these payments and pay them directly to hospitals that provide these services.

Second, we strongly support the establishment of an all-payer trust fund for graduate medical education, and we believe its funds should continue to flow, as they do now, directly to the institutions that incur the costs of training. While it has been suggested that consortia consisting of medical schools and their affiliated teaching hospitals serve as the vehicle for distributing funds, we believe it is more appropriate for the funds to flow as now, directly to the sponsoring hospitals or health systems which bear the cost and in whose venue graduate medical education is conducted.

Mr. Chairman and Members of the Committee, thank you very much for the opportunity to testify.

[The prepared statement follows:]

STATEMENT OF
SPENCER FOREMAN, M.D.
ON BEHALF OF
GREATER NEW YORK HOSPITAL ASSOCIATION

Thank you, Mr. Chairman and members of the House Ways and Means Subcommittee on Health for inviting me to testify before you today on the subject of graduate medical education (GME).

My name is Spencer Foreman, M.D., President of Montefiore Medical Center in the Bronx. Montefiore is the largest non-profit provider of health care and related services to the 1.2 million persons living in the Bronx, a community whose socioeconomic and health status indicators rank among the poorest in the United States. Today, Montefiore Medical Center includes two hospitals; three skilled nursing facilities; the nation's oldest and one of the largest hospital-based home health agency; eight community based comprehensive primary care centers (soon to grow to thirteen providing an estimated 325,000 visits to 120,000 users); a fourteen site multispecialty group practice; an over 900 physician faculty practice providing the full spectrum of specialty care; and a range of other community-based health services, including school health services, drug treatment, and dialysis. In addition, through contracts with New York City, Montefiore provides medical services to two public hospitals, North Central Bronx Hospital and Jacobi Medical Center, and health and mental health services at the 16,000 bed Riker's Island Detention Center. With its roughly 11,000 employees, Montefiore is the largest private employer in the Bronx.

Montefiore is the university hospital for the Albert Einstein College of Medicine and the principal education and training venue for 350 medical students and 1,200 resident physicians annually in its hospital and community-based facilities. I am testifying today on behalf of the Greater New York Hospital Association (GNYHA), a metropolitan hospital association representing 172 not-for-profit hospitals and long term care facilities, both voluntary and public, in New York City and surrounding counties. I am a member of the board and past chairman of GNYHA.

The focus of today's hearing -- Medicare's financing of graduate medical education -- is a subject of keen interest and importance to Greater New York Hospital Association member teaching hospitals. The nearly 800 GME programs sponsored by GNYHA member hospitals constitute the largest concentration of such programs in the U.S. Each year, these hospitals train approximately 13,000 residents representing 13% of all physicians-in-training in the country. As a consequence, New York is a vitally important part of the national infrastructure of academic medicine and is, therefore, particularly vulnerable to any changes in the financing of graduate medical education.

The New York Health Care Environment

New York is presently in the throes of the health care system transformation that is sweeping across the country driven principally by the rapid growth of managed care and resulting in the sharp reduction in both the demand for and the price of hospital services. Presently, approximately 3.1 million residents in the New York metropolitan region -- or 28% of the population -- are enrolled in managed care plans. This number is expected to reach 50% by 2000.

The squeeze managed care has put on New York's hospitals has been made significantly worse by sharp reductions in Medicaid financing in the State of New York. In 1995, the Medicaid hospital budget was slashed by $700 million, and this year the Governor has proposed well over $1 billion in additional cuts.

The movement toward a competitive marketplace is expected to accelerate rapidly with the anticipated expiration of the State's longstanding prospective hospital reimbursement scheme, the New York Prospective Hospital Reimbursement Methodology or NYPHRM. Under NYPHRM, the State establishes inpatient rates for all non-Medicare payers which are designed to contain hospital costs while assuring access to care for those unable to pay. It does this by tying commercial payers to rates paid by Medicaid, thus reducing cost shifting from public to private payers to the lowest level of any state in the country, and by creating innovative payment mechanisms for uncompensated hospital care.

NYPHRM has succeeded in containing costs far better than most observers had anticipated. Studies of health care inflation in the 1980s show New York had among the lowest hospital inflation rates of any state in that decade, an experience that continued in the 1990s. In 1994, New York's institutions had the third lowest net price per inpatient discharge (adjusted for regional differences in wages and illness severity) and the third lowest (wage-adjusted) net price per outpatient visit, of any state. Moreover, through rate setting and public benefit pools for bad debt and charity care and graduate medical education, New York succeeded in creating one system of care for all.

But to achieve and sustain a low rate of inflation and universal access, the State promulgated hospital rates so stringent that even well run institutions had revenues sufficient only to meet their barest costs. While total margins hovered around 4.5% nationally, New York's hospitals could scarcely post a surplus. In 1994, the weighted average total hospital margin was 0.4% for New York State. In New York City, hospitals had a weighted average total margin of -0.5%. Even the private, voluntary hospitals, including some of the best known institutions in the country, just broke even at 0.6%.

After decades of NYPHRM's rigid penury, most New York hospitals had little, if any, cash reserves. The emergence, now, of a competitive health care market has turned a chronic cash shortage into a cash crisis. When lawmakers and the Governor failed last week to enact emergency legislation in the absence of a State budget agreement, causing weekly Medicaid payments to be delayed by a single day, one major hospital missed making its payroll. A number of others would have followed with but a single additional day's delay.

The NYPHRM legislation expires at the end of this month, and State lawmakers are now debating what will take its place. While no final decision has been made with respect to when the new system will take effect, there is agreement that the current rate-setting system should be abandoned in favor of a market based health care economy.

The Role of Graduate Medical Education in the New York Metropolitan Region

America's graduate medical education system is inarguably the finest in the world and the envy of every other nation. With 13% of the country's residents training in member hospitals, the Greater New York Hospital Association community is extremely proud to play so major a role in that system. Moreover, two-thirds of last year's graduates from member hospital programs planned to remain in New York either for additional training or to enter practice; the remaining one-third went elsewhere, 60% to enter practice. Thus, this large health manpower pool supplies well trained physicians to meet the needs of the state and the nation.

But even while in training, residents play an extremely important role in the health care ecology of New York. These doctors are an integral part of the health care team and play a pivotal role in helping the hospitals in which they train meet the health needs of their communities. Nowhere is this more true than in hospitals serving inner city communities which, in general, have not yet become beneficiaries of the growing supply of physicians. New York still has 125 communities, population groups, or facilities designated by the U.S. Department of Health and Human Services Health Resources and Services Administration as health professional shortage areas. Graduate medical education programs in inner city hospitals often provide the only guarantee that individuals and families living in those communities have to access basic health care. Two corollaries are extremely important: such hospitals do not have the fiscal resources to substitute for these physicians; and a very high proportion of physicians in these programs received their basic medical education abroad.

International Medical Graduates (IMGs)

A number of reports in recent years have documented the growing physician supply in the United States. Many, noting this trend with concern, have suggested that the supply is now or soon will be a surplus that must be curtailed. Recently, interest has focused on ways to control the number of international medical graduates who enter graduate medical education as a means of controlling that so-called surplus because many IMGs end up remaining in the U.S. to

practice. It is important to note that IMGs are persons who graduate from medical schools that are not accredited by the Liaison Committee on Medical Education regardless of their citizenship. IMGs are both U.S. citizens and foreigners. In fact, more than half of the IMGs in training positions in the U.S. are either U.S. citizens or permanent residents. Medicare does not currently discriminate in its support of residency programs on the basis of whether the resident is an IMG or a U.S. medical graduate so long as the resident is enrolled in a program accredited by the Accreditation Council on Graduate Medical Education and has passed Parts I and II of the United States Medical Licensing Examination, a standard test administered by the National Board of Medical Examiners to U.S. and international medical graduates alike.

Mr. Chairman, we know that this Committee and other policy makers have been concerned about the number of international medical school graduates trained in the U.S. We also know that the New York metropolitan region accounts for a large proportion of these trainees. In fact, approximately, 50% of all training positions in New York City-area teaching hospitals are occupied by IMGs. Of the nearly 900 training programs sponsored by GNYHA member hospitals, nearly one-third have 100% of their positions filled by IMGS and more than 40% have at least three-quarters of their positions filled by IMGs. Of particular significance, however, is that these positions tend to be concentrated in public and private hospitals serving substantially poor populations. According to GNYHA, 24 high Disproportionate Share Hospitals -- more than half such hospitals in the membership -- have at least 80% of their training positions filled by IMGs. Virtually all of these hospitals are located in economically disadvantaged parts of New York City and some are academic medical centers.

Mr. Chairman, you will likely hear today from others who support proposals to control access to graduate medical education for international medical graduates by recommending, for example, that Medicare make Direct Medical Education payments to hospitals for residency positions only when they are filled by graduates of U.S. or Canadian medical schools, denying such payments in years when they are filled by IMGs. In fact, this Committee has proposed such a limitation in the past. The Institute of Medicine recently proposed replacing the current system of GME payments to hospitals with a voucher system under which vouchers would be given directly to students, with preference going to graduates of American medical schools.

We urge the Committee to recognize that restrictions on Medicare GME financing that specifically target IMGs would have a devastating impact on communities in New York that have the greatest need for physicians, since such hospitals rely on IMGs and lack the resources needed to replace their services. Even if Congress were to authorize a way to continue the flow of funds associated with residency training in order to provide monies for replacement staff, it will take some time to build the pool of staff needed to meet replacement requirements.

Looking to the Future

Congress, the Administration, and others are currently debating the future of Federal support for graduate medical education. Two recently published reports (*The Nation's Physician Workforce: Options for Balancing Supply and Requirements, Institute of Medicine, 1996* and *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century: The Third Report of The Pew Health Professions Commission, November 1995*) make a number of recommendations with respect to the size and funding of the GME system. As Congress debates this issue, GNYHA we would like to offer the following comments and suggestions.

First, we urge Congress to take no action with respect to Medicare funding that will disproportionately affect teaching hospitals. While we share the concern about the solvency of the Medicare Trust Fund, GME represents only a tiny fraction of the overall Medicare budget. We are prepared to accept a fair share distribution of the funding reductions that may be necessary to reduce cost growth in the Medicare program, but deeply oppose any approach that would rely upon disproportionate cuts in GME payments, because such cuts would have a devastating impact on teaching hospitals in New York and across the country.

Second, we urge Congress to maintain its commitment to GME not only for fee-for-service payments, but for Medicare managed care. This is a crucial component in preserving Medicare's support for high quality training and research nationwide. Health maintenance organizations (HMOs) receive monthly payments for each Medicare beneficiary enrolled in their plan; such payment is called the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is calculated under a formula that rolls up Medicare payments for GME, as well as for another crucial public benefit program, the Disproportionate Share Hospital (DSH) adjustment, which is made to hospitals serving extremely large numbers of low income patients. DSH payments are a critical financial support for teaching hospitals. In New York City, teaching hospitals receive almost all of the DSH payments, indicating the tremendous overlap between the hospitals' teaching mission and service to the poor. Nationally, teaching hospitals receive about two-thirds of the DSH payments.

There is no requirement under current law that HMOs pass these public benefits payments on to the hospitals that provide the services and incur the costs, and teaching hospitals around the country are ailing from the failure of HMOs to pay for GME services that are recognized by the Medicare fee-for-service system. Medicare managed care enrollment, while still relatively low in our area, is increasing at a rapid rate, growing in the past year by almost 30%. It is essential that the disappearance of GME and DSH payments into HMO coffers be stopped.

To accomplish this, we urge Congress to enact provisions that would remove, or *carve out* GME and DSH payments from the AAPCC and pay them directly to hospitals that provide these services. The Senate included a limited carve-out provision in its version of the Balanced Budget Act of 1995. We urge Congress to support a full carve-out of GME and DSH funds in future Medicare legislation.

Third, we urge Congress to refrain from attempting to control the supply of medical specialists by involving the government in the allocation of residency positions. If this idea ever made any sense, it was in a fee-for-service environment where many believed that physicians, in general, and specialists, in particular, were uncontrolled cost generators. Managed care has changed all that by providing very powerful incentives to control the inappropriate use of specialty services and sharply reduce the demand for specialists. This shift in the marketplace is already having a major impact on specialty choice among medical school students nationally. According to the National Resident Matching Program, record numbers of students are choosing to enter residency training in one of the generalist disciplines. This year, 54.4% of medical school seniors will be pursuing training in a primary care specialty. Moreover, each of the major primary care disciplines experienced a significant increase over the prior year in the numbers of students entering their programs (family medicine: 9.4%; internal medicine: 2.9%; pediatrics: 6.1%). The market is moving physician training in the direction that many want to see it go; regulatory intervention at this point would only prove disruptive.

Fourth, GNYHA strongly supports the establishment of a Trust Fund for graduate medical education, such as this Committee included in the Balanced Budget Act last year. This would guarantee that the responsibility for paying for the training of our nation's future doctors would be shared by all payers. Such a Trust Fund should be funded at levels adequate to ensure that we can maintain our preeminent training system. While the details of how this Trust Fund would operate need to be worked out, we believe funds should continue to flow directly to the institutions that incur the costs of training. While it has been suggested that consortia consisting of medical schools and affiliated teaching hospitals could serve as the vehicle for distributing funds, we believe that it is more appropriate for the funds to flow directly to sponsoring hospitals or to health systems, which bear the costs and in whose venue graduate medical education is conducted.

Fifth, while we recognize that many are concerned about the number of IMGs being trained in the U.S., we urge Congress to move cautiously in formulating policies that are directly targeted to IMGs. Such policies, by definition, will have a disproportionate impact on some of our nation's most essential, but most vulnerable, hospitals. Care should be taken to avoid actions that will create further financial hardship or jeopardize the ability of these facilities to meet their patient care obligations.

Finally, we support the notion of replacement funding for hospitals that voluntarily choose to downsize their training programs. Such funding would enable hospitals to replace residents with other staff who can provide patient care, but as the IOM report pointed out, the need for these funds will be ongoing and should not be viewed simply as transitional.

Mr. Chairman, members of the Committee, thank you very much for the opportunity to testify today. I would be pleased to answer any questions.

Chairman THOMAS. Thank you. To be honest, I am somewhat underwhelmed by the creativity in trying to figure out a way to deal with the current situation.

Mr. Goldfarb and Mr. Brideau, you both indicated that you weren't sure whether—you agreed with Mr. Stark; you weren't sure whether legislation really ought to go forward. And, Mr. Brideau, you urged us to legislate and make sure that the medical payments out of the AAPCC be carved out and sent directly. So, you are either going to legislate, or you are not going to legislate. It takes a lot of energy to get everybody focused on legislating. A long time ago, I said if we are going to spend that energy on legislating, simply carving out the AAPCC payment, we could spend it on some significant change like a general fund, a broad-based support for not only graduate medical education but perhaps some of the teaching hospitals or even hospitals that rely on certain kinds of products to meet their basic needs. I am hoping for a little more radical thinking, if you will.

Mr. Goldfarb, do you honestly believe that if we simply pass legislation that said the DME, the IME, and the DSH are going to be carved out of the AAPCC and that then will be funneled directly to the institutions, that that is going to solve our problem? I mean, obviously, it gives you an incremental change, but can teaching hospitals compete in the current marketplace?

Mr. GOLDFARB. Mr. Chairman, in answer to your two questions—first, can we compete, and second, will a simple carve-out of the AAPCC suffice—and maybe the second question first—it clearly will not suffice. I tried to characterize that as a short-term response. I believe it is critical to our institution that we have that short-term response because we no longer have the opportunity, if you will, to gain access to those dollars even if we do attract those Medicare managed care patients to our institutions.

Chairman THOMAS. Given your structure, it is especially significant in the percentage of folk——

Mr. GOLDFARB. Especially significant with the amount of managed care.

Chairman THOMAS. Yes.

Mr. GOLDFARB. The second question is an interesting one: Can we compete? The answer is yes, we can compete. But, we can not compete and offer the public good services, that are so unique to academic medical centers. We increasingly would be faced with dismantling the infrastructure that provides indigent care, the teaching programs, and so forth, if we simply competed on a flat plane surface with community hospitals.

Chairman THOMAS. Well, there was another analogy to whether we needed English teachers or political science teachers. I do know that this society made a commitment in the late fifties to try to emphasize sciences and that we created scholarships in an attempt to induce folk in a particular direction. I guess, Mr. Brideau, in your response that maybe we ought not to legislate in this area, should Federal policymakers have some concern about what happens? Should we really go Darwin here and let the evolving system determine how these people are going to be educated rather than to try to legislate and lock in a current system, albeit funded slightly differently? Maybe we just ought to let the whole thing evolve and sit

back with Mr. Stark and see what happens. And, that is not necessarily a bad option because it is the old business of what you do when you throw a football. You know, three things happen, two of them are bad. And, when we try to determine what the future is going to be, almost always all three of them are bad.

Mr. BRIDEAU. I think that is very wise, Mr. Chairman. Obviously, government does have a proper role in oversight of the distribution, both by specialty and geographically, of physicians in this country given that the government, both Federal and State, finance a large part of medical education in the country.

On the other hand, what we have seen even in the past 2 years is the marketplace really taking effect. As we look at the residency matches throughout the country, in 1995 and 1996, what we have seen is a significant increase in interest by medical students in primary care disciplines. There is now very significant competition for primary care residences. We have had our best matching years ever in our primary care areas, and we have had extreme difficulty finding residents in the areas of anesthesia, radiology, other specialties that are in oversupply at this point.

The medical students are pretty smart, and they figure out where the jobs are going to be in the future. Now, it takes a little while for the marketplace to adjust. The concern that I would have in any type of legislation around this whole question is that the factors are so dynamic that to predict them in advance is very difficult. And, in the short 25 years that I have been in health care management, we have gone through two eras of physician surplus and one of physician shortage. That pendulum tends to swing too far one way and then the other. So, it is a very tricky area in which to try to manage at the Federal level.

Chairman THOMAS. As we are coming to a consensus that we really do need more primary care folk, in part As case managers, it looks like some HMOs are responding that perhaps we skip that step and move directly to specialists and that we might need someone to make a determination when they come in holding their ear. You do not need a private care doctor, send him to an ear, nose, throat specialist, so you need the ear, nose, throat specialist. It is a very dynamic structure that is clearly going to change.

Dr. Wickless, thank you for your list of recommendations. I agree with a lot of them, and if we can come together as a community, it will help us to urge, where there is agreement across the board, that we move forward in those areas rather than try to hang on to the big bang theory in terms of making a lot of changes. Sometimes incremental change will get us where we need to go.

Dr. Foreman, New York City, we have had an evolving history of the way in which we have funded graduate medical education, some of it, I think, directed historically, especially on the DSH payments, to try to kill two or three birds with one stone, and some folks have utilized that significantly.

In looking at the geographic distribution of international medical students, you tend to be shocked, I think, one, at the concentration, the percentage concentration, primarily in New York and Chicago. Don't you think rather than the current tail wagging the dog, that if we can identify what the problems are, that are not currently being met through this structure, that it would be better to meet

those needs and not hold captive the entire funding mechanism? We need to suggest some fairly fundamental reform, either on the basis of a patient profile, or particular urban areas where we would make those changes, rather than to simply say, let's pass through the AAPCC and that might help us.

One, why does New York City seem to be an area that attracts such a high percentage? Second, maybe we should rethink the whole method of delivering health care in areas that at one time had the best medical delivery structure in the world and at the same time have perhaps some of the most glaring problems.

Dr. FOREMAN. Well, there are several reasons for New York City having such a high number of teaching hospitals. The first is that the hospitals in New York City tend to be very large, simply because everything in New York City tends to be very large. And, that means that they have had traditionally a large concentrated patient population with which to teach and train.

The second thing is that in the absence of adequate financing for the care of the poor and the generous financing historically for graduate medical education, you have the dynamics built right in for the building and maintenance of graduate medical education programs in areas which are surprising.

Your last question, of course, is the fundamental question, which is to say, what would happen to graduate medical education in the United States if we had universal entitlement to health care insurance? And the answer is, I believe that a very substantial number of the programs which we now see in urban areas which are being sustained, at least secondarily, as a means of providing care for poor communities would disappear. Furthermore, I believe that if an experiment which the New York community has been discussing with HCFA, which is to essentially uncouple graduate medical education payment from residency counts, you will see a substantial diminution in the numbers of physicians trained and the numbers of programs sustained, particularly in areas such as we have been discussing.

At the present time, as you know, Mr. Chairman and Members of the Sucommittee, each additional resident results in incremental funding to the program. That creates a very powerful disincentive for reducing programs. I need not point that out. And if one could disconnect that relationship, one could create the opportunity for doing two things: First, providing funds to institutions that are particularly vulnerable, and at the same time disincenticize the very large and complicated training programs that are now being supported.

Chairman THOMAS. Finally, it is not unfair of me, is it, to indicate that probably New York City's concerns would probably need to be dealt with at the city, then the State, and then the Federal level, in terms of the size and the number of the hospitals, the way in which the State assists, and then the Federal Government coming in? Or, do you think we should have the Federal Government step in and deal with the problem, notwithstanding the city and State levels?

Dr. FOREMAN. Well, that is a very difficult question for me to answer because it depends on what you mean by State, local, and Federal action. At the present time, the city of New York is under-

going a budget squeeze which is, if anything, causing a sharp reduction in their support for medical services to the poor. The Health and Hospital corporations have had continuous and rather dramatic reductions in their funding because the city feels that it is at its maximum in terms of its taxing authority, and yet still has a considerable social burden to bear.

The State is trying to cope with its own budget deficits. It seems clear to me, though, that the problem of sustaining care for the poor as well as sustaining payment for graduate medical education is a problem for all citizens and, therefore, needs to be tackled on as broad a base as we possibly can.

Chairman THOMAS. Thank you.

Mr. Stark, do you wish to inquire?

Mr. STARK. Well, I appreciate your testimony, gentlemen, you have pointed out the dangers in trying to define a system. We have defined a system and education, it was an afterthought. Because the system, not your work, is changing, the historic development of your funding stream is being changed.

For example, let's assume for a minute that some people prevail and all of Medicare were turned over to capitated managed care plans. You guys would be in real trouble if we suddenly corrected something now and then we change through other government action the way the government funds flow through the insurance world. When we originally designed Medicare, almost everybody was in a fee-for-service system, so that the money found its way, and you could attract some patients. In my example, you cannot do this. You have lost control, in effect, of your own population.

I do not know what the answer is, but it would seem to me that Medicare's being made responsible for funding about a third of graduate medical education was an afterthought. Perhaps if we are going to do anything at this point, we ought to start from ground zero. I have always felt that we should fund the students, if it is a Federal responsibility. It is a political decision. All of you could compete for the students. They would have the money from us, and they would have to pay us back. If you want them, you would have to charge them enough for your long-range costs.

My theory has always been to charge the graduates an extra point or two on their income for their earning period which would refund the trust fund. You would then have a system of funding the students that was divorced from the insurance plan or poverty plans or anything else.

I cite this example, not as something that I think you all might endorse, but to illustrate the idea of decoupling. When we need rocket scientists, we have in the past created grants to encourage that. If we need medical research in an area, we should fund that as grants. The problem that I see is trying to tie your future to the tail of a kite which has got an uncertain direction and is not apt to do you any good. I am not sure how we can deal with graduate medical education.

So, what I am hearing today are some fixes for a system that is in a real state of flux. I do not know which system we are going to end up with over the next 2 years to depend on for funding. I guess that is still my dilemma. I do not know what you are going to do.

One other thing, I am not much swayed by the idea that students end up with big loans, $100,000, roughly? It seems to me if you take the difference between their starting salary and the next highest profession's starting salary, and spread that over 20 years, you are talking about an education with a marginal increased value of $300,000 or $400,000. Think about that. If they earn $40,000 a year more than a lawyer, over 20 years that would amortize a $300,000 or $400,000. Now, that is a pretty good buy, $100,000 now for $300,000 or $400,000 in the future.

I am not so sure that students should not be funded, if we give them a reasonable way to repay it. You could be funded on tuition and research grants. Now, there may be other iterations of this. I think that is what Bill may have been referring to—I hesitate to put words in the Chairman's mouth—about creativity. I am just afraid that we are going to redo a system that now does not work. It is not what you have done. It is because, we are changing and we have left you sitting there hanging on this thing tied to Medicare fee-for-service payment, The latter is sort of changing and disappearing.

Dr. Foreman.

Dr. FOREMAN. Mr. Stark, it seems to me there are two principles here that would be helpful if we were to separate. The first is that we clearly need to establish a distance between funds which are intended to support medical education and funds which are intended to pay for health care. And that needs to be done across all——

Mr. STARK. That is not the case now, is it?

Dr. FOREMAN. Correct.

Mr. STARK. OK.

Dr. FOREMAN. It is true for Medicare fee-for-service. It is not true for Medicare capitated payments, and it is certainly not true for any of the other payments. So, the first thing, it seems to me—and it seems to a number of us—is that those funds need to be segregated.

Now, how they are applied to the system once they are separated depends on the philosophy that you take. One interesting suggestion you have just made about——

Mr. STARK. If we could just start from where you are and say let's support you while we decide and find——

Dr. FOREMAN. Right.

Mr. STARK. I think you are right on. I mean, I think that is——

Dr. FOREMAN. Well, this Subcommittee had that idea a year or so ago, and it proposed an all-payer trust fund, which I think the whole community of academic medicine endorsed enthusiastically. And, even those of us who were concerned about how the funds would be distributed and all the other issues——

Mr. STARK. Harry and Louise weren't jumping up and down over that. [Laughter.]

Dr. FOREMAN. Well, I don't think Harry and Louise appreciated how much benefit they get from well-trained physicians and how closely connected they were to graduate medical education.

Mr. STARK. My time has expired, Dr. Foreman. Somehow we have taken a system which has been fine—it has funded graduate medical education and the system has healed around it. The tree grew around the wire and it is working. Now, without prejudice,

the system is changing or being pushed to a change perhaps in some areas, and your system doesn't fit that anymore. I think you have hit the nail on the head. By saying that if you decouple payment for health care and medical education, we have to decide what our responsibility as a Federal Government is in funding your activities. That is the same as funding—whether we fund highways or whatever kind of research. There are pressures, and I am sure you will do fine. I have every confidence in your advocates who I see in the lobby. They are good and hard-working, and underpaid. [Laughter.]

Mr. STARK. So, they will work to support the funding. How we structure the next iteration is important, and I would love for the chance to see this Subcommittee work with you. That may not come quickly enough to resolve the problems. I will turn it over to the distinguished gentleman from Louisiana.

Mr. MCCRERY [presiding]. I thank the gentleman.

First of all, let me apologize for getting here after your testimony. I was here on time, which is to say early, and then I had to leave for another meeting, and now I am back. I am sorry I missed your testimony, but I do have some questions that we would like to have you explore. Let me start with Dr. Foreman with respect to foreign medical graduates and the question of foreign medical graduates.

Some say that while foreign medical graduates generally go into primary care residencies, they end up in specialties. If that is the case, then how are we increasing the number of primary care physicians or generalists? And, since most foreign medical graduates do not go home but end up staying here in the United States, or returning to the United States after a short stay back home to practice medicine, isn't the current policy helping to drive up the overall number of physicians in the country?

Dr. FOREMAN. Let us take the questions one at a time. It is very clear that we have had in the fee-for-service system very powerful incentives to encourage physicians to become specialists. As the market shifts to managed care, those incentives are disappearing. And, in fact, we have heard testimony today, some anecdotal, some direct, that there has been a massive shift in the preferences of all young physicians toward primary care specialties and away from the non-primary care specialties. In fact, highly complex specialty programs are now going begging for residents.

We believe that the major change that accounts for this is that information is now reaching students at a time when they are making decisions about specialty choice sufficiently to persuade them that the opportunities in the health care marketplace are in generalist positions, and we are now seeing massive increases in the applications to residencies and family practice, general internal medicine, and general Pediatrics. I do not believe—and I think much of the professional opinion has now changed on this subject—that we still have to worry about, at least in the near term, physicians opting for specialty practices as opposed to generalist practices in a way that would continue the imbalance that exists. So, we can put that to bed.

Now, with respect to international medical graduates, several things are true. They have historically behaved exactly like other

physicians in their specialty choices. Where they could get specialty training programs, they took them. Where they couldn't, they didn't. What they have done, however, is tended to migrate into communities once they were trained, whether as specialists or generalists, where other physicians have been reluctant to go. This is particularly true of isolated rural areas, and it is true in many areas of dense inner-city poverty. That is not an irrefutable fact, and their presence has been a great benefit to the country as a result of being available in places where physicians were hitherto not available.

There is a final question, which is, I think, the most critical one of all, which is whether it is in the Nation's benefit to have more or less physicians. In my view, having sufficient physicians to provide care to every part of the country appropriately is a national benefit that we ought not overlook. If we have more physicians now than we used to have, many of us see that as a very strong plus.

Mr. MCCRERY. Thank you. I will ask one more question and then, Jim, have you ask questions.

Mr. MCDERMOTT. No.

Mr. MCCRERY. To Mr. Brideau.

Mr. BRIDEAU. Yes, sir.

Mr. MCCRERY. Being from Louisiana, I had a little headstart on you there.

You recommend in your testimony that Congress develop a mechanism to provide replacement funds to those hospitals that depend on medical residents that serve high numbers of the poor.

Can you be more specific. Have you got some recommendation for a specific mechanism?

Mr. BRIDEAU. The concern that we have is some of the proposals we have seen are for transition funds, and the issue is that those hospitals will, over time, still need to provide that service.

Obviously, if the numbers of residents that they train actually do not drop, if the international medical graduate numbers stay the same, then those replacement funds are not needed. But otherwise, there does need to be some other funding for those hospitals. We do not have a specific proposal for how we do that, but that is a concern that I think needs to be addressed in terms of looking at the funding. Because if steps are taken to remove significant numbers of international medical graduates, especially from the inner city programs in New York and some other cities, we end up then with hospitals without care givers at that point.

Their ability to recruit and keep care givers, and pay care givers is a critical issue. The concern we have there is without replacement funds of some sort, those hospitals essentially are not able to provide service to the people of that region, and those people do not get service.

Mr. MCCRERY. OK. Anything that you come up with, we would appreciate your sharing with us.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

It is a unique opportunity to have you folks here, and we appreciate your spending the time with us. I think you recognize in the way this hearing has been conducted, how difficult it is to make

policy judgments off the back of a galloping horse, with one member running in and another one running out.

So, I am not sure if some of these issues have been raised already with you. But, I would like to pursue a couple of lines of questioning. One is that when I graduated from medical school in 1963 everybody had a 2 year obligation to this country. In our flurry over the Vietnam War, we got rid of the 2 year obligation for not only physicians, but everybody else in the process.

I have often wondered what would be the impact of having the Federal Government pay tuition for medical school, and then requiring 3 years of service some place.

I am curious, I mean, we are paying for medical education, but when I trained at the University of Illinois, I spent $800 a semester to get my medical education, and the day I finished my training at the University of Illinois, in Chicago, I left. I never paid a single dime back to the people of the State of Illinois.

I wonder, your response is to some kind of "this for that," that is, pay for tuition in exchange for some years of public service.

Dr. FOREMAN. That has been part of your tradition and mine for some time. The National Health Service Corps was enacted into law some time, as I recall, in the middle to late sixties and has been funded at various levels since that time.

It has been a very successful program. Generally speaking, it has attracted more interest among students than the government was willing to apply funds to. It has not been possible to get funding for all the people who wanted to enroll in that program.

Now, if what you are suggesting, Dr. McDermott, is that in exchange for receiving a medical education, in general, even if you have paid for it, you ought to be——

Mr. MCDERMOTT. No, only if your medical education has been paid for by the government, then you are required——

Dr. FOREMAN. If it has been paid for by the government, I think that there would be—no problem, so far as I know, in generating enthusiasm among students for the National Health Service Corps program as it now exists, and I think it would be a great benefit if more funds were available and such physicians were then given the opportunity to serve in health shortage areas as repayment for the support they received.

Mr. MCDERMOTT. What percentage of your students are able to pay their own freight in terms of their tuition?

Dr. FOREMAN. I do not have the numbers at my fingertips, but I would think that the overwhelming majority of medical students, one way or another, get some sort of support, either in loans or in scholarship——

Mr. MCDERMOTT. At the University of Washington, the average debt coming out is about $80,000 for 4 years of medical school. So, they have obviously had to borrow quite a bit to do it.

Dr. FOREMAN. Right.

Mr. MCDERMOTT. And you are saying that is about the same for you?

Dr. FOREMAN. Oh, the Association of American Medical Colleges has that data, keeps it on an annual basis, quite currently can tell you precisely what the level of debt is. I do not have it at my fingertips, but somebody in the room may be able to provide it.

Mr. MCDERMOTT. How about the rest of you? If you were to provide an education at government expense and then your graduates would have to go and spend 3 years some place?

Mr. GOLDFARB. Mr. Chairman, Mr. McDermott, I guess if I can answer the question a little different way, part of the problem with the National Health Service Corps and Public Health Service commitments, as you know, is the durability of the commitment of the student and young physician, once they get in a rural community, for example.

And, we found that programs like WAMI, from Washington, as well as the Area Health Education Program, has been a more durable program in placing students, as early as their first year in medical school, in homes in rural communities where they can establish some attachment to the culture there, and in fact we now see our students moving to those communities, staying because they have built ties there.

So, I am unsure that just a financial incentive, that in fact is short term, will solve the problem, if that problem is a durable relationship between a practitioner and a community.

Mr. BRIDEAU. My only addition to that, Dr. McDermott, would be to first agree, generally, that you do need both, but that it is not an either/or question. That is we have a number of programs where we place residents in rural areas, and place them—and medical students as well—for 3 and 6 months at a time, to get to know the community, understand what it is like to practice in the community, and get rid of some of the myths of what it is like practicing in smaller communities.

That coupled with a significant financial incentive to practice, especially to practice primary care in those communities, would be very effective, and would be enthusiastically received by graduates at our school.

Dr. WICKLESS. In our profession, the Osteopathic profession, our average graduate debt this past year was a little over $93,000. The thing that many people do not recognize is that this debt is after tax money, and with respect to Mr. Stark's comment, it may be a good value, but it is going to come to the point, I think, that as these debts go up year after year, as the years go by, that, you know, the debt is going to be unmanageable for students, and something will have to be done to change this.

The people have to have loan forgiveness funds, that are scholarship funds to go to an immediate area, be sponsored in a rural area, if that may be the case, or an inner city area. The National Health Service Corps is a good idea, but it probably needs some fine tuning.

One thing I would like to point out is that a lot of the money that NHSC participants get is just to set up a structure. The rest of it comes from moneys that get generated from Medicaid funds or something like that.

In talking to some of the people that were in the NHSC, it appears, some of their concern is if the block grants come forth, their costs will not be appropriately included in the allocated funds, as are currently recognized in the Medicare rate.

To answer the specific question about payback time for this, we need to have a lot of study done on this. We have a lot of facts and

figures right now about manpower data, if we apply this, we can come up with some solutions.

Changes are going to occur. We might as well make them controlled changes.

Dr. FOREMAN. We have had some considerable experience, now quite successful, in bringing highly qualified, fully trained physicians into practice in the most underserved communities in the Bronx on a permanent basis.

We now have over a 100 primary care physicians practicing in medically underserved areas in a variety of settings. We have 3 large community health centers, 10 community health center satellites, 12 school program centers, and 6 mobile units that provide care to homeless children throughout the city.

It is not as difficult as you think to get highly qualified physicians to work in settings like this. As a matter of fact it is no longer difficult at all.

What it takes, however, is a considerable amount of investment capital and the willingness to do it, and to sustain the early start-up costs until these programs break even.

Our commitment to this is based on our view that we have a particularly powerful social obligation to meet the needs of the community in which we are located.

But, it seems to me that looking at the whole notion of community health centers, how they are funded and how they are structured, would open a door to bringing well-qualified physicians back into urban inner-city areas in a way that has not been thought possible previously.

Mr. MCDERMOTT. If I may just follow up. Are the community health centers staffed by international medical graduates?

Dr. FOREMAN. No, sir. These are American graduates.

Mr. MCDERMOTT. These are American graduates.

Dr. FOREMAN. Yes, by and large. Our own graduates as a matter of fact. These are people who are making career commitments to this. This is not a 1 or 2 year obligation.

Mr. MCDERMOTT. So, they went to Cornell or New York University, or whatever, and how are they paying their debts back, and whatever, in that kind of setting?

Dr. FOREMAN. We are giving them a salary, and they are marrying rich spouses, I guess. I mean, one way or the other, they are paying their debts. [Laughter.]

Mr. MCDERMOTT. May I ask one other question.

Chairman THOMAS. After that answer, you go forward at your own peril.

Mr. MCDERMOTT. Well, this question is in a different area. The University of Washington's medical school is funded from 11 percent State money, 39 percent doctors' money, and 50 percent Federal money.

Now, why should not the States pick up a bigger chunk of that cost?

Why should it be 50 percent Federal money? Why not give 40 percent of what the Federal commitment is now, and ask the States to pick up the balance?

Mr. GOLDFARB. Well, Mr. Chair, Mr. McDermott, coming from across the river, I am actually envious of the State support provided by the State of Washington.

Actually, the percentage is a little bit higher, maybe 13, 14 percent for our medical schools. But, for an entire institution is that same 13 or 14 percent, for all of our health professions, across the board. So, some of those programs, let us say the School of Nursing, that are unable to generate as much clinical revenue, and peer review dollars to support their activities, have a much larger State component.

As you well know, the State of Oregon appears to be in no position at this point to provide additional dollars with the property tax law that was recently passed, and their commitment to the criminal justice system.

So, the answer is we are wagged by that tail, and that we do need a Federal commitment that spans the vagaries in State funding across the country.

Mr. MCDERMOTT. How about the rest of you? Could your States pick it up? How about New York?

Mr. BRIDEAU. We are a private university, University of Rochester, so we get essentially no State support on the medical school side. We rely very heavily, though, for our faculty salaries, on funding from the National Institutes of Health. We have about a $100 million in sponsored research. that is a very large part of it.

The tuition payments from students make up about 6 percent of the total medical school budget. So, the key pieces are the income earned by faculty from seeing patients and the research dollars that are received. But essentially, it is that coupled with our endowment income that finances all of the undergraduate medical education.

Obviously graduate medical education——

Mr. MCDERMOTT. So, your Federal support is 75 percent of your budget?

Mr. BRIDEAU. For the undergraduate medical school, essentially, yes, through research funding and Medicare/Medicaid revenues.

Dr. WICKLESS. In Michigan State University we have a College of Osteopathic Medicine. We have a retention rate, that is something over 60 percent of the graduates that stay within the State, and continue to practice in the State.

The number of people that stay there are primarily primary care. The State funds that go toward this initiative is well returned. The trouble with our society today is we have a very mobile society, and where people go to school and where they end up living later are two different things.

I think, historically, that people end up, you know, practice where they train, in residency programs more so than in medical schools. To lay it all on the shoulders of the State, is probably inappropriate, because the places where these people train—and I am a fine example of that, coming from the Midwest and ending up in Michigan—are not necessarily where they finally practice medicine.

It probably has to be a little bit broader based than a State-only initiative, though it is something they have to contribute more to.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman's time has expired, and I believe he said a little bit more of the load to be picked up by the State, rather than the State assuming the whole load. And, I apologize for not being here for this entire discussion, because you may find this is an area where there is a great deal of shared interest of the Subcommittee on some solutions that have been suggested.

I would say that rather than incentive, Mr. Brideau, or that idea might generate some enthusiasm, Dr. Foreman, my model is closer to the ROTC model, in terms of, a direct commitment, if in fact we do this for you, you will do this for us, for stated periods of time, and that there is nothing wrong with the sweat equity concept in terms of earning a very valuable ticket.

The other thing we are looking at is if in fact it is $80,000, or $100,000, there are an awful lot of people in small business who look at that amount of money in terms of going into business, given the resources that I am going to receive.

In other words, the asset debit sheet. That if you started off with that small amount on the debit side, given what you can do on the receipt side, that that is not a bad deal at all, in terms of simply creating a funding mechanism to work it off, not in a scholarship way but in a pure business sense.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank, you, Mr. Chairman.

Actually, some of my questioning will follow up with what Dr. McDermott was talking about, except with a little bit different twist to it.

That is, he was talking about undergraduate and medical education tuition being paid for. We already have a system that pays currently out of Medicare for graduate medical education.

One of the ideas that I have heard proposed, that is very promising, is the idea that the money obviously follows the physician in training, wherever they decide to go.

Coupled with that, if you say to that physician, that is fine, you can go wherever you choose to go; however, an obligation that you will have—what Chairman Thomas was talking about—is that these are the areas in the country that you have to choose from now for receiving that graduate medical education training, subsidized by Medicare. These are going to be the areas in the country that will owe us 3, 4, or 5 years.

I graduated from veterinary school at Colorado State, and we have a similar situation, where they actually paid for part of our training, and we had to go back to your State for 3 of the 5 years.

Very high compliance with that simply because you are looking at either paying back $50,000, or working 3 out of the 5 years in your State. And it works very well. You do not have to take it, but then, again, you have to pay. It is a good deal for the taxpayer, but it is also, a very good deal for making sure that underserved areas like, New York City, some of the rural areas, or whatever, are served, in a manner that, without coercing people, just lay it out to them.

Would any of you like to comment on that?

Dr. FOREMAN. I did my——

Mr. ENSIGN. Let me make one quick comment that you can follow up on.

You know, we have talked a lot about just hospitals here. First of all because of a voucher type situation where residents go where they want to go, are hospitals the best and the only place that we should have residencies?

Dr. FOREMAN. In answer to your first question, I would like to say that I did my training in Federal facilities or facilities under Federal sponsorship. Then I moved to private facilities, incurred a payback obligation, and ended up spending 11 years as a Public Health Service officer in uniform. So, I believe I can comment with some degree of personal authority on this.

It is a system that works, but what it does not, it seems to me, do, is get people reliably to stick in the areas in which you send them, after they have finished their training.

It seems to me that it is a terribly vital adjunctive policy. There are areas, quite frankly, that are so remote, and so difficult to attract people to work in, that the only way to get health services in there is to assign them.

I harken back to the comments I made earlier. I believe that you can attract quality physicians to move into at least urban underserved areas by creating practice environments which will draw them, and that the way that we ought to approach that problem, it seems to me, is to be certain that the facilities and organizations capable of building such systems have the means to do that and encourage these physicians to practice in underserved areas.

It is my sense that without that, we will have revolving door medicine.

Mr. ENSIGN. What is wrong with that? I mean, right now——

Dr. FOREMAN. It is better than nothing, but it is——

Mr. ENSIGN. Right now, we have graduate medical education and we have residents that basically are revolving door. That is an improvement from the current situation, but it is not incurring more cost.

As a matter of fact, the way I believe that we should do it—we talk about international medical graduates. Right now, if we want to pare those back, which I believe that we should, we could say to American graduates that these are available to you. That would still take care of the underserved, because New York City and Chicago, and a few other places, are the places that are telling us that they are going to be really hurt if we cut back on the number of international medical graduates.

But, if you had the voucher type system, they would be able to be served.

Dr. FOREMAN. I do not think there is any question that you would get a good many takers.

Mr. ENSIGN. Yes. OK. Mr. Brideau.

Mr. BRIDEAU. I would like to address your second question, if I could, on, are hospitals the best place to conduct graduate medical education?

The answer is yes, they are the best place through which to sponsor graduate medical education, but even today we obviously do not conduct a large part of medical education in the hospital setting itself. We all have a number of programs, either in inner city areas, rural areas, of ambulatory settings, a whole variety of settings.

So, less and less of medical education takes place inside the hospital today. More and more takes place in the ambulatory services that we all have and are establishing throughout the community and our regions as well.

But, to have the hospital as the base for the sponsorship gives you the wide breadth of services, wide breadth of educational experiences that residents need, that other organizations would have to then go out and find hospitals to contract with to get those.

I would say hospital sponsorship is still the key, but the site of training needs to be much more like the real world of the practice of medicine.

Dr. WICKLESS. Just a little bit different response. By the impact of managed care, what we have seen is the hospital sense of all institutions going down and the downsizing of institutions. And what we have seen is an increase in the people using outpatient facilities whether it be free-standing surgery centers, or what have you.

What we have to do is train people, residents, where the people are going to be. I do not think we can ever get away from academic health centers and we always should sponsor them, but there has got to be more money pushed over into the area of developing ambulatory health care center sites, and with the advent of technology today one of the better things that you do get out of a hospital setting is, you know, the conferences, the lectures, and so forth.

With telemedicine and things of that nature, you can be at a remote area, yet receive all the interactive and intercommunication that you need to keep up your skills and advance your skills.

Mr. ENSIGN. Mr. Chairman, just real quickly, based on the McDermott clock.

Chairman THOMAS. I would tell the gentleman that the more senior Member of the Committee was given a privilege which may or may not extend. [Laughter.]

If it is requested, it might be, but if it is demanded, it may not be.

Mr. ENSIGN. Mr. Chairman, I will not follow the ROTC approach here. I would beg a—humbly——

Chairman THOMAS. The gentleman may continue. [Laughter.]

Mr. ENSIGN. Just following up on this whole idea, because I think that it is such an important concept that we explore. We also have to look at the idea of residencies in hospitals, especially in the inner cities. That becomes the place where people get the primary care, which is also the most expensive care that they can possibly get, is in emergency rooms, which is where a lot of the residents end up treating these people.

The idea of ambulatory care in situations outside the hospital obviously needs to be addressed, but also the idea of perhaps that we have too many residencies funded in this country, and if you decrease those, but you incentivize people to go in and set up private practices because they are going to have the graduate medical education funded, those same people, if they go back to the inner city, set up a private practice. Perhaps there is more incentive there to get people treated, maybe in community-based clinics, that are much lower cost, overall, to the whole health care system, than the current system of treating most of those indigent type people in our emergency rooms.

Mr. GOLDFARB. Mr. Chair, or Mr. Ensign, I think the managed care wave in this country, in fact, incentivizes just what you describe. We are now financially incentivized to go to the community and not bring the community to us. And as a result, like many of my colleagues, our institutions establish what we call community health centers, and many of our best residents in fact end up at least initially practicing there, and then moving into the community.

What you are describing is in fact happening as the financial incentives in the system have changed to those that are more primary care based.

If I might also answer part of your question about placing students or young physicians in undesirable locations.

It has to be two part. It cannot, in my view, simply be at the graduate medical education level. At the undergraduate level, we also need to get the students into those environments. So, there is a better chance that they will stick, if they have an obligation, whether it is a PHS obligation or other in those communities.

Mr. ENSIGN. OK. I thank the Chair for the Chair's benevolent indulgence.

Chairman THOMAS. I would tell the gentleman from Nevada he is getting much better. [Laughter.]

Before I call on the gentlewoman from Connecticut, I just want to say, and acknowledge, that in this area we have tried to be creative, and I indicated I was a little underwhelmed by some of your solutions, since they were more the obvious ones, and we are looking for some responses in a real world context which will allow us to better understand.

No one has been more responsible for providing creative alternatives in dealing with graduate medical education than the gentlewoman from Connecticut.

Mrs. JOHNSON. I thank the Chairman, and I was interested that only one Member even mentioned some of the proposals that we have been making. This is a very big problem. We are going to have to have a far more dramatic series of presentations than we had this morning to get to it.

Many of you have talked with me personally, and had engaged at a different level, but I thank the gentleman from Nevada for really getting in there with some of the issues that have to be dealt with, as Dr. Wickless began to deal with them.

First, because there are a number of questions, and anyway, I might not be granted the liberal treatment of preceding Members, I need some information on a number of issues.

First of all, is managed care draining your education resources? Now, Mr. Goldfarb, you had managed care around you for a long time. We have not done anything. I mean, we tried in our preservation act, but we have not done anything to deal with the fact that managed care does allow resources that were supposed to support medical education to be diverted to other needs of the managed care system, including profit.

Have you seen any kind of diminution of resources for medical education?

Mr. GOLDFARB. Mr. Chairman, Mrs. Johnson, absolutely. The fact in Oregon is that half of those Medicare patients that formerly

had access to our institution, with the pass-throughs to support graduate medical education, attached to their State, are no longer available to us.

Yes, the patients do come, but we compete for managed care contracts for those, and the health plans retain those dollars themselves.

Mrs. JOHNSON. OK. Have any of you done any analysis? After all, we have kept DME money flowing. IME money go directly to you. DSH money go directly to you.

There are a lot of money that flow directly to you. The only little piece that does not is the piece of the AAPCC that goes through the actual reimbursement for that patient.

Now patient stays have diminished, so you would not be getting those anyway. Have you done any analysis of what percentage of your medical education dollars are being compromised by managed care? We need to know that, because if we do not have a good premium for managed care, we will not be able to buy the quality plan that seniors need.

So, if it is only a small percentage of your money, then let us deal with it through the trust fund, which is exactly what we tried to do. We put new tax dollars into the trust fund and kept the AAPCC high.

So, the logic was to put a good premium out there to buy a good plan, that would better serve seniors, so they can actually get more benefits than Medicare currently provides, and give hospitals the replacement dollars.

We do need to know from you a much more precise estimate of what the contractual negotiated loss is. Now, you have to in fact draw out what will be the estimated reduction in length of stay, because you would not have been able to count on that, whether it was managed care or not.

If you want to comment, and I do have other questions, so do not belabor it, if you do not have any information.

Mr. BRIDEAU. Go ahead.

Mrs. JOHNSON. Thank you. Consortium funding. But, do get back to me. I know I am asking for information you do not have.

Consortium funding. I am very interested in consortium funding, and many of you have made the point that the old way of training residents, in hospital, will not meet their practice needs.

But, consortium funding is going to have the same impact on the New York hospitals as reducing the number of IMGs, because if you are going to train them out of hospital you are not going to have the hospital soldiers to do the work, in hospital.

Now, is that going to be a problem? Have you thought it through? Do you have a consortium proposal? Would it help if we were able to give reimbursements for the training of advanced practice nurses and physicians' assistants, and people like that?

So that we look at what is the in-hospital component of all medical training that we should be funding versus in the context of the kind of consortiums that we really are going to need, and in not too many years are going to be typical of all medical education funding.

What is it going to do to your hospital labor when we go in that direction? And, do any of you have consortium proposals that you

would like to pilot for us, so we would know that it was a good idea to put pilot dollars out there?

Dr. FOREMAN. Let me tackle just a little piece of that. There is some confusion, I think, in using the term consortium, in which several different ideas are being commingled. That the consortia that are being proposed, or have formed in New York, are basically clusters of teaching hospitals and their affiliated school, coming together, to try to parse a rational system of training by specialty among the various institutions.

Consortia are likely to be ambulatory care facilities under hospital sponsorship, and as such are funded under the Medicare Act.

The ambulatory care sites that are not funded under Medicare are those that are not part of a hospital system, but there are very substantial numbers of ambulatory care sites and activities which are part of the hospital system, and in which training takes place, for which Medicare provides full funding.

A number of organizations, including our own, has advocated that funding be extended to ambulatory care sites that participate in the graduate medical education process, even if they are not a part of hospitals, simply because, right now, they are excluded from participation on the basis of being unable to recover their cost.

But, I do not think there is any quarrel, certainly among our institutions, that they should be given the opportunity, if they are being engaged in the training process, to recover the costs associated with that.

Now with respect to the consortia themselves, they are likely to be essentially position-allocation mechanisms rather than an activity that changes the way graduate medical education is conducted.

So that instead of five institutions, each having an ophthalmology program, perhaps two would have them, and somebody else would have something else.

It is not likely that they will get involved in the other aspects of changing graduate medical education funding.

Mrs. JOHNSON. Dr. Wickless.

Dr. WICKLESS. A couple comments, and first, about managed care, and just to point out a piece of information. I practice about 30 minutes from the University of Michigan, which is one of the larger academic medical centers in the United States, and have a lot of interaction with them because of patient referrals.

There is an article published by one of the physicians up there in the New England Journal, that talked about the decreased staffing needs in academic medical center based on a managed care model.

If you look at those numbers, and equate those numbers, and the amount of money that would go through a system based on a tax, you realize that the amount of money that would be going through there, that would be fed back to the educational process, is going to diminish.

I do not have any other studies in reference to managed care, and GME sources.

Number two, we have two initiatives in our profession. The first one is in Michigan. It is COGMET, Consortium for Osteopathic graduate medical education and Training. And, it has evolved into

a statewide campus system which is co-sponsored with our institution, College of Osteopathic Medicine at Michigan State University.

There has been a similar initiative recently implemented in the last 2 years in Ohio, CORE, The Centers of Osteopathic Regional Education Program Our profession is predominantly based in smaller hospitals scattered throughout regions, and because of this ability we are able to put all these hospitals and link them together with the benefit of a medical school, Osteopathic Medical School in these regions, or State, as it is here, that put together this consortium to get all these needs together that we want to.

This allows people that are in smaller hospitals to link with our telecommunications that we are developing, you know, back to a central area where they can get the academic, didactic things they need to continue the residency program, in the process, while they are out in the rural or smaller areas.

Mrs. JOHNSON. Thank you.

Mr. Brideau.

Mr. BRIDEAU. Thank you, Mrs. Johnson.

If I might, in the area of managed care and the response to the HMOs, essentially we have done an analysis of our costs as opposed to other hospitals in Rochester, and we are clearly the most expensive.

When you take out the teaching costs from all of the hospitals in Rochester, we become the third most expensive hospital.

When we talk to HMOs, they are not interested in paying us the prices that we have because we are a teaching hospital. They want to pay us that average cost, essentially, of the community and are saying, effectively, that they are not going to pay for graduate medical education.

My concern about providing AAPCC payments that include the GME component is that the HMO has that payment in hand, and basically is saying to us, we will pay you like a community hospital but we will not pay you for your teaching costs.

Mrs. JOHNSON. Right. The question I was asking was, how much of the difference between your being number one and number three are we already reimbursing through DME and IME, and other streams of funding?

And how much——

Mr. BRIDEAU. It is going directly to us.

Mrs. JOHNSON. And, directly to you. So, we do need more—I see my time has expired, so I will pursue my other questions later.

But, we need to know from you what you think in the long run is going to be the impact of the consolidation of hospitals, the restructuring of programs as we probably change the level of reimbursement for advanced levels of certification, so that we begin to look at what is going to be the total number of residency slots, in hospital, and how is that going to compare to the number of graduates of American medical schools.

There has been a tremendous increase in the number of foreign medical graduates into our system, and should we be negotiating with foreign governments to have contracts that provide some foreign dollars to support that training, and along with it contracts for people to return to their country to better utilize that training for the purposes for which presumably their Kindergarten through

college system investment in them by their National Government prepared them for.

So, there are some big sticky wickets here to think about, and while we are keenly aware of the problem of the inner city hospitals and their dependence on foreign medical graduates, I do not think that can shield us from the seriousness of the challenges we face, nor does it make those problems insolvable when you look at the number of reductions in residency slots elsewhere in the system, and the need to train people like advanced practice nurses.

Thank you.

Chairman THOMAS. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

I indeed want to welcome the witnesses today particularly Dr. Foreman who had such a distinguished career in Baltimore at Sinai Hospital. It is nice to have you here before our Subcommittee.

I agree with the point that most of you have made about the AAPCC dollars. Those funds should be directly used for graduate medical education.

But, I also agree with the point the Chairman has made. if we just provide the necessary funding, without dealing with accountability how the funds are going to be used, in order to deal with the problems that have been acknowledged by all of you, that that would be wrong. we would miss perhaps the only opportunity that we have in establishing national health policy to deal with the work force issues.

We have had difficulty in this Congress dealing with the work force issues because some believe that the market forces will work; others are somewhat suspect about that.

I just want to echo the comments that Mrs. Johnson made and the Chairman made about coming forward with recommendations that are workable in dealing with the underlying problems of work force allocation.

It is not just the number of medical students that we are training in graduate education. It is not only the geographical disparities that exist. But, it is the type of specialists that we are training in this country.

Because of the large numbers—140 percent of the medical students—we produce too many physicians trained in certain fields, not enough in other fields.

Certain communities have enough; other communities do not. Some fields have too many trained, and in many other fields we do not have enough trained.

Yesterday, I had the chance to visit the geriatric center at Hopkins, and was somewhat surprised to learn that there are only 200 fellowships in the country in geriatric medicine.

We all know that our society is changing, getting a lot older, the frail elderly is a growing number. It would seem to me that that is one area that is not very glamorous, may not pay a lot of money as far as a field of medicine to go into, but as we look at work force issues, that is an area that we need to concentrate on to make sure that we are going to have adequate personnel trained.

So, I just want to underscore the point, that from a person who strongly believes that the Federal Government must have a dedi-

cated funding source for graduate medical education, that the tradeoff must be to deal with these work force issues.

I want to underscore one additional point that has not been made, and that is, the major teaching public hospitals are really coming under attack today.

It is very, very difficult, when you look at the type of patients that you treat. You have got two and a half times the number of Medicaid patients that the typical hospital has—36 percent of your revenues versus 14 percent of their revenues.

You have three times more uncompensated care than the typical hospital in this Nation. And you have, it looks like, one-half the number of private paid, that a typical hospital would have.

So, your revenue flow from traditional sources is going to be more difficult. Therefore, it becomes even more important to establish a flow to deal with training costs, so that we can maintain the excellence in training in this country.

So you have our attention. There is a real desire for us to do something in this area. But I would just urge you, as a group, to take very seriously this opportunity and be a little bit bolder in coming forward with recommendations that will deal with the multiple problems we have in the work force.

We know it is not a simple solution. But, I really do think that our major teaching facilities are in jeopardy if they miss this opportunity, where you have our attention, to try to deal with the problems.

I would certainly welcome any comments any of you might have on that and give you a chance to respond.

Yes, sir?

Mr. BRIDEAU. If I may, Mr. Cardin, just comment on the shortage of geriatricians. There is no question about that, there is a significant shortage. I would point out, though, a report this morning on National Public Radio indicated that half the geriatricians in this country are foreign medical graduates.

This is not a simple issue, getting residents to go into specialties that we need.

Mr. CARDIN. Because I might point out that many times these residencies are the only ones open, so the foreign students end up in these residencies too.

Mr. BRIDEAU. So, they do go into them. We welcome the opportunity to provide you with some additional proposals, and will certainly do that. But getting back to the basics, though, one of the concerns that we have is we are concerned about the Medicare reductions that are being proposed in the Balanced Budget Act, and the impact that they will have, especially on teaching hospitals, because in addition to being hit on the regular across-the-board cuts, such as the marketbasket adjustment, and those sorts of things, if we, in addition to that, get hit for direct medical education, in disproportionate share, because we do treat a disproportionate share of the poor, that is a double hit to these kinds of hospitals.

So, to begin solutions to the problem, you first need to stabilize the base of where we are, to a degree. We are deeply concerned about the viability of some of these institutions with those kinds of reductions.

Mr. CARDIN. I Appreciate that.

Mr. Chairman, I yield back the balance of my time to any of the other Members who may wish to use it.

Chairman THOMAS. I was just going to say that that is just a little bit unfair, when you look at the program that we had from the House side, putting $17.5 billion into that general fund. There was not a desire to reduce the funding. There was a desire to shift the basis of the funding.

To argue that somehow, graduate medical schools and teaching hospitals suffered an unfair reduction vis-a-vis everything else, is simply not the case, and I would like to visit with you.

The idea of moving to the general fund to finance it, notwithstanding our desire for initiatives in the marketplace to deal with it, underscores how much all of us here, whether Republican or Democrat, believe that these institutions have a significant role to play.

But, we are not going to continue the current system, and either you folks who are doing it help us figure out a new way, or we will do it for you. I prefer having you folks help us, beyond telling us that the built-in costs you were supposed to get out of the AAPCC ain't coming your way right now, and that is your solution.

I know that is an unfair representation of what you said, but it ain't that far off.

The gentleman from New York. We had an interesting discussion, introduction of a gentleman from your area, and he keeps referring to the Finger Lakes area repeatedly, and you now have a chance to question him.

Mr. HOUGHTON. The garden spot of the——

Chairman THOMAS. Garden spot; right.

Mr. HOUGHTON. Thank you.

Well, Mr. Chairman, you have got other panels, and I will not take long. I have three questions, but they can be answered rather rapidly.

One is in terms of—I would like to focus this on Mr. Brideau, because he and I have been associated up there over the years.

Really spell out for me, again, how the changes in the payment factors are going to disproportionately affect your hospital.

Second, I would like to know the impact of telemedicine, and spreading the costs.

And third, maybe you could answer this, or maybe the others could. What have you done as far as reducing your basic costs?

We heard a man from Beth Israel talk about some pretty staggering cost reductions he had made over the past few years. We talk about reimbursement and we talk about revenues, but I do not know whether we have talked sufficiently about the basic cost base.

Mr. BRIDEAU. Let me take the last one first, if I could, Mr. Houghton, and then work back up.

In terms of cost reduction, just to deal with the reduction in revenue from governmental and non-Governmental sources in the last several years, we have had cost reduction programs at our hospital each year.

Last year, for example, we eliminated $15 million from our costs. We eliminated something on the order of 200 jobs at Strong

Memorial, and those are people who just are not working there anymore.

On top of that, this year we are putting in place an additional $14.6 million of cost reduction. This is just to stay even with the hit we have been taking on the Medicaid side, largely, and from business. The message we are getting from business is loud and clear. They want to see their premiums come down as well.

This is at a hospital that is already one of the more cost-effective teaching hospitals in the country.

Budgeted for next year will be similar cost reductions. So, people are losing their jobs, we have no way around that. Our nursing hours of care per patient day have declined. We are looking for ways to do things more efficiently.

So, we are not arguing for maintaining the current system. We know that is not possible. We are not arguing for business as usual.

But, we are arguing to not be hit, disproportionately. To go to that portion of the question, if our Medicare payments are about $130 million, in total, in the hospital. About $30 million of that is graduate medical education payments.

So, if we take a reduction on, for example, the marketbasket factor, that reduction affects the whole $130 million of revenue. But, if we also take reductions on graduate medical education payments, either through direct reductions in DME, or through reductions in the IME factor, that is a reduction, again, on that $30 million. So, it is a double hit from that standpoint.

We are also a disproportionate share hospital, so anything that happens on the disproportionate share side affects us as well.

So, we recognize that we need to be a part of a solution here, both in terms of the Medicare Trust Fund, and the balanced budget. What we are simply arguing for is a fair portion of that solution, and sort of an equitable portion of that solution.

In the area of telemedicine, we are actively involved in establishing a telemedicine network throughout the Finger Lakes region to keep us in touch with rural hospitals, because in our view, what makes most sense for patients is not for them to travel from 60 miles away, or 80 miles away, to come to Strong to receive their care.

But, wherever we can safely and effectively provide that care in their home communities, we think they ought to stay in their home communities.

The electronic infrastructure is not quite what it needs to be to fully support that, and we are working with the telephone companies and other companies, to put that in place. We think that holds significant promise, and certainly any grants in the development of that field would be very helpful for communication and for treatment of patients in those communities.

Chairman THOMAS. The gentleman from Washington wanted to inquire.

Mr. MCDERMOTT. I just had one last question, Mr. Chairman. I appreciate this.

You mentioned your relationships to HMOs. I wonder if there has been any approach to any of your hospitals by a managed care operation that wants to take over the hospital, just take over a uni-

versity hospital as a part of their operation, and as a part of inserting themselves into the teaching and training of physicians.

Mr. GOLDFARB. Mr. Chair, Mr. McDermott, not in our case. The health plans in our area are competing, frankly, viciously with one another, and I would suggest they would not want to take on the additional cost and burden of care in an academic medical center, and then have to compete against other health plans on an even playingfield.

That may be happening in other parts of the country, but, I have not yet seen it in ours. We have health plans that own clinics and want to work with us in rotating our residents. Some health plans are part of systems, they own clinics, and therefore, they want to expose our "best and brightest" to their outpatient programs and to rotate the residents there.

Mr. MCDERMOTT. So they come to you, asking that you rotate your people into their programs?

Mr. GOLDFARB. Mr. McDermott, exactly, and unfortunately, I am unable to say, well, if you will do that you need to send more of your inpatients to us. No. They want to negotiate that against other tertiary facilities in the area.

Mr. BRIDEAU. We have not had that experience in New York. The experience we have is that of HMOs essentially wanting to deal with us, and wanting to do a number of things collaboratively with us, but at a price that is competitive with community hospitals.

Mr. MCDERMOTT. But, if you are the only tertiary care center in the area, how are you competitive?

Mr. BRIDEAU. We are the principal tertiary referral center, but there are other hospitals, in the Rochester, Buffalo, and Syracuse areas that they can send patients to for those kinds of services.

We also provide secondary and primary care as well. What I want to do is get a clarification, if I can, to some of the data that we have been asked to provide around the impact of this, and dealing with the HMOs, because the easy rule of thumb, it seems to me, is that if 10, 15, or 20 percent of the business of Medicare is in HMOs, in a managed care environment, that is 10, 15, or 20 percent of the GME money that we are not getting.

Because the price they are willing to pay us is the price of a community hospital. They are not willing to pay for education.

So, if you have got a 20 percent penetration of managed care in the area for Medicare, you have lost 20 percent of your GME money. It is a one for one relationship.

Dr. FOREMAN. It is important to recognize that even hospitals that provide highly specialized care only do so for about 20 percent of their business. The other 80 percent is routine care and can be provided by a number of other providers in the community. Unfortunately, the costs are laid across the entire care spectrum, so that even if you could command the actual cost of your premium services from HMOs in the community, you still have a premium laid on your routine services ascribable to charity care and teaching, which no one will pay for, and which is now causing HMOs to march away from teaching hospitals and do business with their lower cost competitors.

There are some things, though, short of protective payments, that we think offer some promise for large teaching hospitals.

We have begun to bundle services and negotiate capitated payments from HMOs, and provide physician services, hospital services, specialty services, and ancillary services for a comprehensive fee, essentially stepping into the shoes of the HMOs and taking full risk capitation.

There have been some proposals before Congress to create provider-sponsored networks under Federal law, and that would go a long way, I think, to facilitating institutions like ours, and in upstate New York, to gathering an organization of other institutional providers, physicians, and ancillary services under a single roof, and then managing the care within a single premium dollar, in a way that protects both the public and the private benefits that are necessary.

Mr. MCDERMOTT. Has there been any medical school in New York, that you know of, that has been approached by a major HMO organization offering to actually pay tuition for medical students, and then train them so that they could join their program?

Dr. FOREMAN. No, sir. The last thing in the world HMOs want to do is pay for training. They would like somebody else to pay for training and then benefit from the products that are trained.

Mr. MCDERMOTT. Thank you.

Chairman THOMAS. Well, that is one of the areas we should be a bit more inventive in terms of examining. If they want certain kinds of physicians, there might be a way in which we can affiliate slots, or some other structure, and if they do not want to fill them, they do not get filled.

You know, there are a number of ways, I think, that we can be a bit more inventive. We, after all, are trying to figure out a better way of funding than the average area per capita cost, to begin with, and while we are doing that, in creating that general trust fund we were required, because we were not creative enough, to simply use the current distribution structure for those dollars that otherwise would have been sent out as DME, IME, and we left DSH out at the final end.

But, we did set up a commission to try to study a new way to distribute the money, and my hope is that as we begin moving toward solutions, that we could adjust the method of payment with some risk selection factor that needs to be worked on, and change that distribution structure.

Because we have got a number of teaching hospitals that, historically, by location, are basically inner city. We have a patient profile that, in part, comes with that location. And that is, in part, different from who gets trained and why. So, we have a lot of areas that we could be working on, to try to be a bit more creative.

I hope that some of you, although your testimony is primarily focused by virtue of the organizations and institutions that you represent, realize you are our primary source of understanding of the changing nature of the health care delivery system.

I would hope that you would respond to us from a personal point of view in as innovative and creative way as possible. We have had suggestions of simply pulling emergency care away from the traditional structure and run it under a societally funded operation like fire stations, to a certain extent, or other options that would allow

us to begin figuring out ways in which we can get a societal response for a societal benefit.

All of us here believe that the teaching of our future physicians is a societal benefit, and we have got to figure out a way to broaden that base, but to do so, in a way in which we do not create additional problems that the current system is obviously giving us.

I want to thank all of you for your testimony. Thank you.

If we could ask the second panel to come forward.

I want to thank this panel, consisting of Dr. Jacott, who is a member of the board of trustees, American Medical Association; Dr. Patrick Harr, who is president-elect of the American Academy of Family Physicians; Dr. Leslie Cutler, who is chancellor and provost of health affairs, University of Connecticut, Health Center, Farmington, Connecticut; Dr. Anthony Marlon, who is the chief executive officer and director of Sierra Health Services in Las Vegas. I have a hunch my colleague from Nevada may want to do some additional introductions. And Dr. Reeves, who is a senior vice president of the Health Care Operations, Sierra Health Services, Las Vegas.

Do you want to do some elaboration at this time?

Mr. ENSIGN. Yes, thank you, Mr. Chairman.

I would like to recognize both gentlemen and say how much I appreciate Dr. Marlon and Dr. Reeves for being here.

They represent Sierra Health Services, which is truly one of the more innovative health care companies in the country, not only from the State of Nevada, but truly, across the country.

They recently qualified for the SHMO, Social Health Maintenance Organization, II pilot project, one of three in the country, and so many other things, and I am just proud that they come from the State of Nevada. We have a lot of great things from our State, and this is just one of the great companies that we have in Nevada, and I thank them both for being here.

Chairman THOMAS. Thank you.

I would indicate that if you have written testimony, we will make it a part of the record, without objection, and you can proceed to inform us in any way you see fit, with the admonition that we are looking for bold and exciting new ideas.

We have heard all the old ones, but if you want to fill your time by telling us all the old ones again, we are more than willing to listen.

Dr. Jacott.

STATEMENT OF WILLIAM E. JACOTT, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. JACOTT. Thank you very much, Mr. Chairman, and Members of the Subcommittee.

My name is William Jacott. I am a family physician and I am head of the Family Practice Department at the University of Minnesota, and a member of the AMA board of trustees. We appreciate this opportunity.

As you have been discussing in your first panel, the Federal Government is the only payer to reimburse the costs of GME.

In the past, the private sector has contributed indirectly, but in the current competitive environment, the plans, the systems, the

groups are becoming less willing to pay the higher charges associated with the teaching hospitals.

In addition, the private sector is less willing to allow their physicians to be involved in voluntary teaching. Therefore, the growth of managed care has placed increased pressures on medical schools and teaching hospitals as more individuals enter into those plans, systems, and networks.

As you pointed out, Federal GME dollars are also lost through the AAPCC, but that is not the whole story.

The latest Trustees' Report on the Medicare Part A Trust Fund makes it clear that Medicare cannot, and should not continue to bear the sole burden of paying for our Nation's graduate medical education.

Medicare can reduce its burden, but only if the private sector begins to pay its fair share. It is important to note, that resident physicians provide a large amount of care to poor and underserved.

Some hospitals are heavily dependent on the medical services of resident physicians, and thus, any changes need to take those situations into account.

As you recall, Mr. Chairman, last year, the AMA presented Congress with a proposal to restructure Medicare, and a portion of that proposal involved GME. The AMA recommend that there be a 2 year transition period for changing the existing GME funding formulas to end the steady increase in costs.

During this period, Congress should limit full GME funding to the years leading to initial board certification, which is usually about 3 to 5 years, plus the full length of training programs in geriatrics and preventive medicine.

Second, we believe Congress should delegate authority to some kind of public/private consortium to make recommendations on work force and on funding of GME.

This group should obviously consider specialty mix, geographic distribution, and total numbers of physicians.

Third, we must restructure the financing of GME into an all-payer pool, which recognizes that patients covered by all forms of insurance benefit from trained physicians.

In addition, GME funds should be distributed to the entity that incurs the cost of training, and as you have discussed previously, payment currently to the hospital. That is the only way it is paid now, and actually, much of our training programs are in the ambulatory setting.

Fourth, the task force would develop a new indirect medical education adjustment funding mechanism. This would require careful study, because you know that is a very complex issue, and it cannot allow hospitals to bear a disproportionate share of any of those funding reductions.

Any changes to the IMEA must have an adequate transition period to allow hospitals to adjust for that.

Now just a couple of comments, in closing, about the IOM and the Pew work force reports. We commend the Institute of Medicine for a very thoughtful report.

We agree that in many areas in the country, there are too many physicians, and certainly, too many specialists. Certainly in my area, in the Twin Cities, we are seeing this significantly.

The marketplace is making some change, as has been pointed out, but Federal funding should be adjusted according to national needs.

So, we urge the Congress to authorize the development of that consortium, and the consortium needs to look at entry levels in both medical school and in residencies.

We could continue to believe that residency positions should be filled based on competence and merit, and not on discrimination.

We support the position of the IOM, that it is not prudent to open any new medical schools, not to increase current enrollments. We disagree with the Pew report, however, that we should be closing medical schools.

Each of our schools has a unique mission and role in meeting a variety of needs in their region, and our decisions today will clearly impact the work force in 8 to 10 years, because that is the pipeline.

So, in conclusion, we look forward to continue working with the Members of Congress in achieving the fundamental reforms needed to assure a quality national physician work force for our patients. Thank you.

[The prepared statement follows:]

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

RE: GRADUATE MEDICAL EDUCATION

Presented by William E. Jacott, MD

June 11, 1996

Mr. Chairman and Members of the Subcommittee:

My name is William E. Jacott, MD. I am a family physician, Head of the Department of Family Practice at the University of Minnesota School of Medicine, and a member of the Board of Trustees of the American Medical Association (AMA). On behalf of the AMA's 300,000 physician and medical student members -- and the millions of patients we serve -- I am pleased to have this opportunity to testify regarding Medicare's financing of graduate medical education (GME).

BACKGROUND

As you know, the federal government is, in general, the only payer to explicitly reimburse the costs of graduate medical education. Medicare contributes to the funding of graduate medical education through two payment streams. The direct medical education payment (DME) covers the salaries and fringe benefits of resident physicians, supervisory time for physicians who participate in training resident physicians and allowable overhead related to teaching. The Medicare indirect medical education adjustment (IMEA) originally was introduced to compensate hospitals for the increased costs associated with the presence of an educational program that could not be attributed to resident and attending physician salaries, the greater complexity of care provided in teaching hospitals due to the generally higher severity of illness of the patient population, and the uncompensated care that is provided that could no longer be supported through some cost shifting to Medicare patients.

It has been estimated that Medicare pays about 30% of direct graduate medical education costs through the DME. In the past, the private sector has contributed through paying the higher charges associated with medical care provided through teaching hospitals. In the current competitive environment, however, the private sector is becoming less willing to pay higher charges to support the training of future physicians at both the undergraduate and graduate medical education levels.

The growth of managed care has placed increased pressures on medical schools and teaching hospitals in several ways. First, the revenues that are used for educational program support are being negatively impacted by the increasingly competitive environment. Second, the patient base in teaching hospitals is decreasing, as more individuals enter into managed care plans, which restrict enrollee access to certain physicians and hospitals. This decrease or loss of a patient base compromises a critical element in the training of physicians.

In addition, federal GME dollars are lost through increased enrollment in Medicare managed care plans. While the average adjusted per capita cost (AAPCC) formula used by Medicare for risk based managed care programs includes medical education within the per capita payment, there is no requirement that the managed care organizations participate in medical education as a consequence of receiving the funding.

The latest report from the Trustees of the Medicare Part A Trust Fund makes all too clear the fact that Medicare cannot -- and should not -- continue to bear the burden of paying for our nation's graduate medical education. The participation of both the public and private sectors in financing medical education must be examined, and a mechanism developed to ensure an equitable contribution from all parties to preserve this national resource. Medicare can reduce its burden in financing GME, but only if the private sector begins to pay its fair share to support graduate medical education -- education from which the private sector continues to benefit.

However, the necessary restructuring of graduate medical education financing should not result in unplanned, negative consequences to teaching hospitals, which provide a high level of specialized care and care to the uninsured and underinsured, or to medical schools, which carry out both educational and research missions. It is important to remember that resident physicians also provide a large amount of care, often to poor and underserved populations. There are hospitals in some areas of the country that are heavily dependent on the medical services of resident physicians. Therefore, any changes in funding for graduate medical education should evaluate the effects on institutions with teaching programs, taking into account specialized regional needs and circumstances.

AMA PROPOSAL

Last year, the AMA presented Congress with a bold Transforming Medicare proposal to reform Medicare based on a competitive market driven system. The AMA's proposal provided for a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. While we were pleased that many of our proposals were included in the Medicare Preservation Act (which was incorporated into the Balanced Budget Act of 1995), we continue to support the comprehensive changes to the graduate medical education system found in our Transforming Medicare proposal.

Transitional Period

First, the AMA recommends a two year transition period for changing the existing funding formulas for direct medical education payments and indirect medical education adjustment to halt the current steady increase in costs. In this period, Congress should introduce differential weighting for a preset number of training positions into the existing funding formula for direct medical education payments and limit full funding to the years leading to initial certification by the 24 specialty boards recognized by the American Board of Medical Specialties plus the full length of training programs in geriatrics and preventive medicine.

The AMA recommends this transition period because we understand it will take time to develop and implement an all payer system for graduate medical education. While this is being done, the current funding formulas for graduate medical education under Medicare should be modified so that programs are not financially rewarded for increasing the number of residency positions.

Public/Private Task Force On Physician Workforce/Medical Education Financing

Second, the AMA believes Congress should delegate authority to a public/private physician workforce planning initiative to make recommendations about the need for physicians and the funding of graduate medical education. The AMA, the Association of American Medical Colleges and American Osteopathic Association would convene a task force of representatives from the medical professions from the various institutions/programs that are engaged in graduate medical education, the federal government, in addition to representatives from the states and private payers.

This task force would be charged to study physician workforce needs and to make recommendations about the future funding of graduate medical education, in the context of workforce needs as impacted by managed care and the use of non-physician providers. In developing its recommendations, this body would consider such things as specialty mix, geographic distribution and appropriate training for the emerging health system. There should be appropriate protection for the Task force from antitrust exposure arising from planning activities. The task force would submit a comprehensive report to Congress outlining its recommendations.

Creating An All Payer Funding Mechanism For GME

Third, the AMA strongly believes we must restructure the financing of graduate medical education into an all payer system. An all payer system recognizes that patients covered by all forms of insurance benefit from trained physicians and so all payers should contribute to the costs of that training. The relative percent contribution of the federal government to the all payer pool should not exceed the current proportion of total graduate medical education costs paid by the government. Eventually the total costs to the government can be decreased once the private sector begins to pay its fair share. In addition, GME funds should be distributed to the entity that incurs the costs of training, whether that entity is a medical school, hospital, nursing home or ambulatory clinic in order to encourage training outside of the teaching hospital.

Changing The Current Funding Formulas For GME Under Medicare

Fourth, the task force would analyze the current indirect medical education adjustment and consider the development of an appropriate funding mechanism to reimburse for the increased complexity of care/severity of illness in teaching hospitals. The current direct medical education payment and indirect medical education adjustment under Medicare are structured without limits on the number of residency positions that will be funded. This is a stimulus to increase the number of physicians in training. In addition, the IMEA discriminates against non-hospital based teaching settings by only allowing payment for hospital-based residents.

In addition, the indirect medical education adjustment has been used to compensate teaching hospitals for additional costs of patient care due to the presence of an educational program, but mainly for costs associated with the higher complexity of care and provision of uncompensated care in these institutions. The IMEA originally was designed to take the place of a complexity of care adjustment to diagnosis related groups in the Medicare prospective payment system. The IMEA should be analyzed and a new mechanism to allocate costs based on complexity of care should be developed. This requires careful study, to ensure that certain categories of hospitals are not bearing a disproportionate share of any funding reductions. Furthermore, any changes to the IMEA must be made over an adequate transition period to allow teaching hospitals to adjust for potential payment differentials.

Decreasing The Number Of Funded Residency Positions

The Council on Graduate Medical Education (COGME) has reported to Congress and to the Secretary of Health and Human Services (DHSS) over the past several years that the numbers of physicians being produced in the United States is exceeding what is required in both total numbers and by specialties. COGME has recommended that Federal funding policy be directed toward adjusting the total number of physicians being trained downward and the distribution toward generalist be increased.

The Institute of Medicine (IOM) and the PEW Health Professions Commission each recently issued reports which, in the main, reinforce and support these positions previously put forth by COGME and others. The AMA fully appreciates the problems set forth by these reports in terms of the supply of physicians increasingly exceeding the requirements for the national

good, and that the distribution among the different specialties is not optimal. Further, the AMA concurs with the general principles set forth in these reports that federal funding of GME should be adjusted to bring the physician supply into better alignment with national needs.

Because the AMA recognizes that not all groups can or will agree on tactical details for remedial action, the AMA strongly urges the Congress to authorize a new public/private workforce planning initiative to pursue the details of physician workforce strategy, as described earlier. In the interim, gradual reductions in Medicare outlays for GME can be initiated to both relieve Medicare expenditures as well as to begin a reduction in physician output. If there are to be any reductions, it should be made clear that positions should be filled based on demonstrated competence and merit, not based on irrelevant or arbitrary factors or discrimination.

The AMA supports the positions of COGME and IOM that it is not prudent to open further new medical schools (both allopathic and osteopathic) nor to increase current enrollments. The AMA disagrees with the PEW recommendation that some medical schools should be closed. Medical schools are a national resource beyond the simple training of physicians. Each school has a unique mission and role in meeting the variety of diverse needs across the country. Furthermore, if we misjudge the number of physicians needed for the future, it would take years and very large investments to restore medical schools that may be closed. We strongly urge that any adjustment in physician supply leave the current number of medical schools, but instead make changes through medical schools reducing class size.

While many details of these reports need reconciliation through a national workforce planning program, there are a number of other suggestions in these reports with which we support. For example, the IOM report recommends that data be collected on the relative difficulty physicians are encountering as they complete their residency in finding suitable practice positions. With support from the Robert Wood Johnson Foundation, the AMA has already started this ongoing study and published the first years findings in March 1996. Information on opportunities by different specialties will be included later this year in an on-line program to be available to all medical students as they select their residency.

CONCLUSION

The AMA is aware of and sensitive to the multiple problems facing the Medicare program today. We have offered recommendations on how to decrease the Medicare outlays in general in our proposal of Transforming Medicare. In addition we have proposed a reasoned plan for addressing the issues of Graduate Medical Education. In particular we recommend:

1. that the Federal government authorize a new public/private physician workforce initiative to make detailed recommendations about the need for physicians and the funding of graduate medical education;

2. that the financing of GME be re-structured into an all-payer system;

3. that the current indirect medical education adjustment be analyzed to assess how to develop an appropriate funding mechanism to reimburse teaching hospitals for the burden of increased complexity of care/severity of illness and disproportionate share; and

4. that the number of GME positions be gradually reduced over a period of several years to address the needs put forth from the new public/private physician workforce initiative consistent with the need to improve Medicare fiscal solvency.

We look forward to continue working with members of Congress in achieving the fundamental reforms needed to assure a quality, national physician workforce for our patients.

Chairman THOMAS. Thank you.
Dr. Harr.

STATEMENT OF PATRICK B. HARR, M.D., PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. HARR. Thank you, Mr. Chair, Members of the Subcommittee. My name is Pat Harr. I am a country family physician from rural Missouri, here today representing the 83,000 members of the American Academy of Family Physicians. Thank you for the opportunity to discuss Medicare GME reform and, in particular, the recent work force reports, the Pew Health Professions Commission in the Institute of Medicine.

Both the IOM and Pew Commission Reports make clear that now is the time to substantially reform GME policy. Both reports provide a clear definition of primary care and substantiate the need for more primary care physicians. Moreover, the IOM Report shows that, primary care is defined not just by how physicians are trained but what they do.

I am also here today to describe how Medicare GME policy can be changed in order to move the health care system where it needs to go and, that is, to achieve a system with a firm foundation in primary care. Whatever proposal Congress may eventually choose to adopt, the cost explosion in the Medicare Program will not be brought under control until the availability of primary care services is improved.

Medicare GME policies are largely responsible for the overspecialization of the physician work force. What powerful incentives are at work in the health care market are illustrated by the high demand for primary care physicians and challenges faced by subspecialists in finding the employment of their choice. The dollars for training come primarily from Medicare, which richly rewards institutions for training providers of inpatient and procedural services. This misalignment of Federal incentives must be addressed.

We acknowledge that redirecting Medicare GME dollars toward ambulatory and primary care training may cause some dislocations in the hospitals currently receiving these GME funds. However, the fact that training institutions will have to undergo change must not dissuade Congress from reforming Medicare GME. By removing the conflicting incentives of Medicare GME and managed care, these institutions can bring their service and training missions into alignment.

In making the following recommendations, we emphasize the importance of acting now. Because the current physician oversupply is so large and the training pipeline so long, any changes enacted now will not have a perceptible impact on the physician supply for some decades to come.

To address the physician surplus, a limit should be placed on the number of funded first-year allopathic and osteopathic residency positions equal to 110 percent of the number of U.S. medical school graduates and phased in over a period not to exceed 5 years. In addition, a national consortium should develop recommendations on the number of funded residency positions, taking into consideration societal need for these services, the number of graduates from U.S.

medical schools and the patient care needs of institutions that have a high proportion of residents who are IMGs.

In order to increase the number of physicians practicing primary care, Congress should establish an initial target of training at least 50 percent of new physicians in true primary care programs whose graduates enter primary practice. In determining eligibility for GME funding, quality should be the primary criteria. Other criteria should include the public's need for health care services, the demonstrated geographic location and career choice of program graduates, and whether or not the program truly produces generalist physicians. In addition, special consideration must be given to the needs of inner city and rural areas and to increasing the number of minority physicians.

The national consortium would determine the national average per resident amount as well as factors responsible for legitimate variations in GME payment costs. Eligible institutions for receipt of GME payments would be those sponsoring residency programs, which would include the teaching hospitals, medical schools, HMOs, group practices, federally qualified health centers, approved training consortia and other entities, such as the ambulatory-based programs.

The consortium should determine the indirect costs of GME, in ambulatory and inpatient training facilities, with both inpatient and ambulatory training sites eligible for payment. The distribution of GME funds should be accomplished through the individual programs. Alternatively, the allocation of funding could be accomplished through the approved regional or state training cooperatives. The consortium should undertake studies to assess the adequacy of the physician supply, as well as other studies relating to the mix of physicians and distribution of health care services.

Finally, the Academy believes that the direct, indirect, and transitional costs of graduate medical education should be distributed across all payers, public and private alike.

I would like to thank you for this opportunity to speak with you about the graduate medical education program and I look forward to answering any questions.

[The prepared statement follows:]

STATEMENT OF
PATRICK B. HARR, M.D.
AMERICAN ACADEMY OF FAMILY PHYSICIANS

My name is Patrick B. Harr, M.D., and I am President-elect of the American Academy of Family Physicians. In addition, I am in private family practice in Maryville, Missouri. On behalf of the Academy's 83,000 members, I appreciate the opportunity to address issues related to Medicare's support of graduate medical education (GME) and, in particular, the recent workforce reports of the Pew Health Professions Commission and the Institute of Medicine.

The Pew and IOM Reports in Context

The Pew Health Professions Commission and the Institute of Medicine are to be commended for producing comprehensive, timely, well-documented reports with many thought-provoking recommendations. These reports, however, should be viewed in the context of a three-decade history of similar reports, all of which have come to similar conclusions about composition of the U.S. physician workforce. What is remarkable is not so much the reports' recommendations regarding the size and specialty mix of the U.S. health care workforce, but, rather that policy makers have for so long failed to act on similar recommendations.

Thirty years ago the Millis Commission warned that the physician workforce had become overly specialized. Many other reports over the ensuing years have arrived at similar conclusions. Yet, the situation is far worse today. Mr. Chairman, what the Pew and IOM reports show us is that the health care system has evolved; what defined the American health care system in the past is not what defines it now or in the future. Yet, the bulk of our health care resources are still directed at inpatient, subspecialty care and research, while health care itself has moved out of the hospital and now places much greater emphasis on primary and preventive care. If there is one take-away message from the Pew and IOM reports, it is that it is time to stop studying this issue and start implementing corrective action.

Given the history that lies behind these reports, it is also important to avoid becoming distracted by their many individual recommendations, although each of them is worthy of debate. What is important is the reports' clear vision of where the U.S. health care system is going. That vision is one in which our health care system has a firm foundation in primary care. The Academy believes that current federal GME policies are severely misaligned in regard to where the health care system needs to be, and the failure to realign those policies has forced the federal government and the country as a whole to pay an extremely high price in terms of health care cost, quality, and access.

U.S. health care system is, in may ways, failing to meet the health care needs of the country because it is so overly specialized. Cost, quality, and access have all suffered. That is the price of failing to reorient the incentives driving health care training institutions with the health care needs of the nation. Higher costs mean not only larger federal budget deficits, but also unaffordable health insurance and greater numbers of uninsured individuals, whose care is more expensive and of lower quality. As we all know, uninsured individuals are eventually able to get health care, but it is often delayed, results in poorer outcomes, and is more expensive than it would be with ready access to primary care. Furthermore, those of us fortunate enough to have health care insurance wind up paying for the costs of caring for the uninsured anyway. With employers becoming less likely to provide health care insurance, this is a problem that is getting worse, not better.

Defining Primary Care

One of the most significant contributions of the IOM report is its detailed definition of primary care. As the contribution of primary care to health care delivery has become more widely recognized, having a clear, accurate definition has become more important. Primary care is not a simple range of tasks but rather the broadest, most comprehensive mode of health care delivery, and it is that part of medical practice with the greatest amount of uncertainty. Not all health care providers are inclined by personality or training to cope with the inherent uncertainty of primary care practice.

As defined in the IOM report, "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Value of Primary Care

Both the Pew and IOM reports emphasize the contribution of primary care to health care cost, quality, and access, a contribution that is largely unrealized by a health care system oriented toward specialty care. Both reports also note that the future of the health care system lies in primary care.

The Academy recently commissioned a study by the Barents Group, LLC of KPMG Peat Marwick, LLP, which examined the value of primary care. *The Role of Primary Care Physicians in Controlling Health Care Costs: Evidence and Effects* is a comprehensive review of existing studies on the role of primary care physicians in controlling health care costs. Among the findings of the study are:

- Primary care physicians produce services in a more cost-effective manner than do sub-specialists, with comparable outcomes.
- A significantly larger proportion of all necessary and appropriate health services could be provided by primary care physicians than is currently the pattern in the United States, offering the potential to reduce health care costs without sacrificing services or affecting outcomes.
- Projected Medicare outlays could be reduced significantly if the mixture of primary care physicians to sub-specialists were altered.

Specifically, the study indicated that Medicare spending could be reduced by at least $48.9 billion and as much as $271.5 billion over the next six years if primary care physicians were 50 percent of the total physician workforce. The analysis revealed a direct correlation between the availability of primary care physicians and the reduction of health care costs.

This study and others like it illustrate a glaring reality of American medicine: it is overly specialized and overly costly, and the two factors are directly linked. No matter what proposals the Congress may choose to adopt, **the cost explosion in the Medicare program will not be brought under control until Congress improves the availability of primary care services.**

Primary Care and Managed Care

Both the Pew and IOM reports tie the rise in primary care to the expansion of managed care. While it is true that managed care is able to achieve quality improvements and contain costs by emphasizing primary care, the benefits of primary care are no less applicable and no less important in the fee-for-service sector. The KPMG study referenced above demonstrated substantial Medicare savings to Medicare in its traditional fee-for-service program.

Misalignment of Federal Incentives

Medicare GME policies are largely responsible for the over-specialization of the physician workforce. These policies promote training in expensive inpatient settings and emphasize the procedurally-oriented subspecialties rather than in family practice and other generalist specialties. Medicare GME payments go exclusively to hospitals, where subspecialist physicians are primarily trained, rather than to ambulatory care sites, such as clinics and offices, where generalist doctors receive much of their training. A May, 1994 General Accounting Office (GAO) report reiterated that "barriers to primary care training persist in Medicare's payment method."

Medicare GME expenditures are expected to reach $6.3 billion dollars this year. Medicare's GME support constitutes an open-ended entitlement for hospitals that are able to establish accredited residency programs of any size and in any specialty without regard to local or national health care needs. The lack of accountability along with Medicare's incentives toward inpatient and sub-specialty training constitute an irresponsible use of tax-payer dollars. Reforming Medicare GME in order to both control GME expenditures and account for their use requires that

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the federal government (1) establish broad national goals in regard to the physician supply and (2) align Medicare GME spending to achieve those goals.

The only current federal programs specifically targeted at increasing the supply of primary care providers are authorized by Title VII of the Public Health Service Act. However important these programs might be, their influence on the physician workforce is minor compared to Medicare's GME support. The annual funding for these PHS programs is less than $150 million as opposed to $6.3 billion in Medicare GME support and $11 billion in NIH research and training funding.

Market Incentives

Powerful incentives are at work in the health care market. The job market for physicians is changing dramatically; with primary care physicians in high demand and gainful employment in a number of subspecialties no longer guaranteed in every location. Medical school graduates are clearly reading the market signals before choosing residency training. For example, both the number of family practice residency positions and percentage of those positions that are filled are at an all-time high. While this is an encouraging trend, it has strained severely our training programs. Because family practice training is based largely in ambulatory settings, and because the major source of financial support for GME, Medicare, is almost entirely directed at hospital-based training, our residency programs are finding it increasingly difficult if not impossible to make ends meet. For example, there are currently over 1100 faculty vacancies in family practice residency programs, primarily because these programs are unable to offer competitive salaries.

Notwithstanding the above paragraph, it is essential for the members of this Committee to understand why market forces have limited impact on training institutions. The driving forces in the health care market are the purchasers of care, be they individual patients, health plans, or employers. These entities purchase health care services, either at the individual level, or at the level of a health plan. None of these entities purchase health professions training. Indeed, it makes little sense for a health plan to pay for training, because the benefit of an individual health plan's investment in training is not restricted to that plan. In economic terms, health professions training is a public good. Health care providers, with the exception of those with obligated scholarships, can go wherever they wish upon completion of training. Even if the bulk of health plans were to provide training support (there are a few that do) leaving training decisions to health plans would, by no means, ensure that national health workforce needs would be met.

To the extent that they also provide health care services, training institutions will respond to the market's demand for health care services. However, the dollars for training come from other sources, primarily from Medicare, which richly rewards institutions for training providers of inpatient care and procedural services. What these institutions face is a growing conflict between the incentives signaled in Medicare's GME support (inpatient and procedural services) and the signals of the health care market place (ambulatory and primary care services). Traditional, inpatient-oriented training institutions that may wish to respond to the market's new incentives do so at the peril of losing Medicare GME dollars, in some instances, substantial dollars.

Impact on Teaching Hospitals

It is well known that Medicare GME dollars are used by a number of training institutions to subsidize the provision of health care services to indigent patient populations. That is, Medicare GME is supporting the provision of health care services rather than its intended educational purposes. Furthermore, these training programs tend to train physicians in specialties that are already over-supplied. Redirecting Medicare GME dollars toward institutions that provide ambulatory and primary care training may cause some dislocations in the hospitals currently receiving GME funds. While Congress may wish to establish a separate fund to soften the impact of these dislocations, the fact that training institutions will have to undergo change must not delay Congress from undertaking the task of reforming Medicare GME. It no less important for large inner-city teaching hospitals to develop their own primary care base than it is for any other health care institutions. By reorienting their training programs toward primary care, these institutions

could also qualify for ambulatory and primary care training dollars. Furthermore, by removing the conflicting incentives of Medicare GME and the increasingly managed care market, these institutions can more easily bring into alignment their service and training missions.

Recommendations

The Academy offers the following recommendations for reforming Medicare's GME support. As noted earlier, controlling Medicare GME expenditures and responsibly accounting for their use requires that Congress establish broad national goals for the physician workforce and align Medicare GME spending to achieve those goals.

A number of concerns have been raised in regard to the federal government's taking a more active role in directing the expenditure of Medicare GME funds. The most frequently raised concern is that the federal bureaucracy will be unresponsive to changing health care needs and that distortions in the supply of physicians will persist in one form or another. We note that the current physician oversupply is so large and the training pipeline so long, that any changes put into place now will not have a perceptible impact on the physician supply for years to come. Similarly, there will be ample opportunities for mid-course corrections.

Another concern that has been raised is that targeting the expenditure of Medicare GME funds to meet national workforce needs will impinge on the academic freedom of training institutions. We believe this concern to be misplaced. Requiring accountability for the expenditure of public dollars is wholly different from determining the structure and content of training programs.

Finally, Medicare GME reforms have been criticized for potentially constraining the specialty choices of medical school graduates. In fact, it is the current Medicare GME support that constrains choice. As noted above, changes in the market are influencing graduates' choices of residency training. Because of the inpatient and subspecialty bias in Medicare GME funding, training institutions are hampered in their ability to respond to those changes.

Aggregate number of eligible residency positions

In order to address the aggregate physician surplus, an initial limit should be placed on the number of eligible first-year allopathic and osteopathic residency positions equal to 110 percent of the number of U.S. allopathic and osteopathic medical school graduates. This limit should be phased in over a period not to exceed five years. A national consortium (see below) should develop recommendations on the number of eligible residency positions taking into consideration societal need for physician services, the number of students graduating from U.S. allopathic and osteopathic medical schools, and the patient care needs of institutions that have a high proportion of residents who are international medical graduates (IMGs). As part of its ongoing duties, the national consortium should re-evaluate its recommendation relative to the aggregate number of eligible residency positions.

Primary care - non-primary care distribution

Because of the extreme over-specialization of the physician workforce, Congress should set a goal of increasing dramatically the number of physicians practicing in the primary care specialties of family medicine, general internal medicine, and general pediatrics. To achieve this goal, Congress should establish an initial target of training at least fifty percent of new physicians in programs whose graduates enter primary care practice. However, the national consortium described below should be permitted the flexibility to recommend an implementation plan that differs from the initial target percentage provided that its recommendation is based on scientific and analytical data and that the recommendation remains fully consistent with the goal of increasing dramatically the number of physicians practicing in primary care. Furthermore, Congress should specify that under no circumstances should the number of training positions in the primary care programs be reduced below current levels.

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Allocation criteria

In general, quality should be a primary criterion in determining eligibility for graduate medical education funding. Only residency programs that are accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association Council on Postdoctoral Training should be considered for eligibility. Methods for assessing quality should be developed by the ACGME and its Residency Review Committees and the AOA Council. In approving eligible residency programs, other criteria that should be considered include the public's need for health care services, the demonstrated geographic location and career choices of program graduates, and the relevance of curricula to future generalist practice. The Secretary would be required to give special consideration to the needs of inner-city and rural areas and to increasing the proportion of physicians in under-represented minorities.

Direct medical education payments (DME)

The national consortium would determine the national average per-resident amount as well as factors responsible for legitimate variation in DME costs. Eligibility for DME payments would be based on the recommendations of the national consortium consistent with the specified allocation criteria. Entities eligible for receipt of DME payments would be those institutions sponsoring residency programs, which could include teaching hospitals, medical schools, health maintenance organizations, group practices, federally qualified health centers, approved training consortia, or other entities, including ambulatory-based programs.

Compensation for the direct costs of graduate medical education should be based on a national average per-resident amount. Per-resident amounts should be weighted to recognize legitimate variation in direct costs due to variables such as the use of ambulatory training facilities and regional differences in wages and wage-related costs. Entities receiving DME payments would have to submit documentation demonstrating that DME funds are expended only for direct costs of graduate medical education.

Indirect medical education payments (IME)

The national consortium should determine the indirect costs of graduate medical education in ambulatory and inpatient training facilities. Indirect costs include legitimate differences in patient care costs between teaching and non-teaching facilities. Both inpatient and ambulatory institutions serving as training sites for eligible residency programs could receive payments for the indirect costs of graduate medical education.

Transition payments

The national consortium should determine the transitional costs associated with unmet patient care needs in teaching hospitals that undergo a reduction in the number of accredited and filled residency positions. Transitional funds should be derived from an account separate from that used to pay for graduate medical education costs and should compensate for the costs associated with unmet patient care needs in teaching hospitals that are preparing or anticipating a reduction in the number of accredited and filled residency positions. Teaching hospitals initiating reductions in the number of accredited positions should have immediate access to transitional payments. Any phased reduction of transitional funding should be accompanied by longer-term solutions to unmet patient care needs such as an expansion of the National Health Service Corps.

Methods of allocation

The designation of eligible residency positions and the distribution of GME training funds should be accomplished through approved individual programs. Alternatively, allocation of positions may be accomplished through approved regional or state training consortia. In either case, the method of allocation should be consistent with national goals related to the aggregate number of training positions and the primary care - non-primary care mix of specialties.

Research

The national consortium should be required to undertake or commission studies to (1) assess the adequacy of the aggregate physician supply in relation to the public's need for health care services, (2) determine the appropriate mix of physicians in the primary care and non-primary care specialties, (3) assess the geographic distribution of health care services, (4) assess the status of minority representation in the various specialties, (5) determine the direct costs of graduate medical education including salaries, fringe benefits, and associated teaching costs, (6) determine the indirect costs of medical education in inpatient and ambulatory teaching facilities, and (7) determine direct transitional costs associated with unmet patient care needs in teaching hospitals that undergo a reduction in the number of accredited residency positions.

Implementation timetable

Full implementation of Medicare GME reform should be achieved in the shortest span of time that provides an opportunity for teaching hospitals to adjust to changes in their resident complement, for medical schools to adjust their curricula, and for entering medical students to be fully informed of the opportunities for graduate medical education. Five years from enactment is a reasonable target for full implementation.

Primary care practice incentives

Achieving and maintaining a balanced specialty mix will require measures beyond the reform of graduate medical education. It will be necessary to adequately fund the development and implementation of medical school curricula that increase students' exposure to ambulatory primary care training. Those factors that support primary care practice must also be addressed. These factors include increased stipends for physicians in primary care residency programs, adequate and fair reimbursement for primary care services, incentives for practice in underserved communities such as bonus payments, loan forgiveness, special income tax exemptions, and an expansion of the National Health Service Corps, the availability of funds for the capitalization of inner-city and rural primary care systems, and the development of referral and consultation networks.

National Consortium

Medicare's current support of GME is not only misaligned, but it is also rigid. It is probably not possible to design a system that is completely incentive neutral (i.e., one that is fully able to adjust to market signals regarding the desired mix of specialties without resulting in financial gain or loss to training institutions). For this reason, the Academy supports the creation of a public-private workforce consortium. Such a consortium should be broadly representative and, to the extent possible, insulated from the political process. **The consortium would be responsible for:**

- **projecting the aggregate need for the medical care workforce in the health care delivery system;**
- **making recommendations relative to the number of residency positions on a national basis, including the number of international medical graduates (IMGs), and maintaining the appropriate ratio of generalists to specialists;**
- **making recommendations regarding the allocation of residency positions by specialty and subspecialty according to population needs;**
- **recommending appropriate incentives to reinforce the selection of primary care by medical school graduates;**
- **conducting on-going research that will ensure the availability of appropriate data on which to base workforce decisions; and**
- **evaluating and monitoring the efficacy of all recommendations and their implementation, ensuring that the process allows for flexibility, particularly during a transition period, and reevaluating recommendations as appropriate.**

The consortium would make annual recommendations regarding the aggregate number of

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physicians and the distribution of physicians in the primary care and non-primary care specialties. If the Secretary of the Department of Health and Human Services accepts the recommendations of the consortium, then he or she may proceed to publish in the *Federal Register* an interim final rule with comment period. If the Secretary decides to alter the recommendations of the national consortium, then he or she must publish in the *Federal Register* a proposed rule that includes an explanation of the specific areas where the Secretary disagrees with the recommendations of the national consortium and allows for a 60-day comment period.

The national consortium would also monitor and review the decisions of the Secretary of DHHS related to the specific number and specialty mix of approved residency positions in order to assess conformance with national goals. The national consortium could recommend modification of eligibility decisions in order to address the supply of specific specialties that remain in under- or over-supply.

The national consortium should be an autonomous and broadly representative body. It should be composed of knowledgeable individuals who have gained national stature for their expertise in health economics, graduate medical education, medical practice, and other related fields. A majority of its members should come from the medical profession, including practicing physicians in the primary care specialties, physicians who are faculty members of primary care residency programs, and physicians-in-training. The national consortium should be of sufficient size to ensure appropriate diversity in its membership, and it should include representation from the Departments of Veterans Affairs and Defense. The provisions currently applicable to the Prospective Payment Assessment Commission and Physician Payment Review Commission would apply to the national consortium in regard to staffing and administration, compensation of members, access to information, use of funds, periodic GAO audits, and requests for appropriations. Any government officials seated on the national consortium would serve in a non-voting capacity.

All-payer support

While the specific issue of today's hearing is Medicare's graduate medical education support, it must be recognized that Medicare's disproportionate share of the nation's GME burden produces distortions in the GME system related to the specific mission of the Medicare program. Medicare is structured to meet the needs of its elderly and disabled beneficiaries, while health professions training institutions must address the health care needs of the nation as a whole. Therefore, we believe that the direct, indirect, and transitional costs of graduate medical education should ultimately be distributed across all payers, public and private. After projecting the annual expenditures for graduate medical education, an annual GME surcharge should be applied to all health insurance premiums so that all payers contribute a proportionate amount toward GME costs.

Until an all-payer system of GME support can be established, it is essential that Medicare GME support not be decreased precipitously. Doing so will have a disproportionate impact on the most financially vulnerable training programs, which are those in the primary care specialties most needed.

Conclusion

As this committee continues its important work in reforming Medicare GME support, please do not hesitate to call upon the American Academy of Family Physicians. Family physicians are eager to work with you on this challenging undertaking.

Thank you for this opportunity to speak with you about graduate medical education. At this time, I would be happy to answer your questions.

Chairman THOMAS. Thank you very much and I will turn over the introductions of Dr. Cutler to the gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you. It is a pleasure to welcome Dr. Cutler here today. I have worked with him on many of these kinds of issues over the last 2 years. I am pleased he could be with us today and be a part of this point of the discussion.

Thank you for being here, Dr. Cutler.

STATEMENT OF LESLIE S. CUTLER, D.D.S., Ph.D., CHANCELLOR AND PROVOST, HEALTH AFFAIRS, UNIVERSITY OF CONNECTICUT HEALTH CENTER, FARMINGTON, CONNECTICUT

Dr. CUTLER. Thank you. First, let me say thank you to the Chairman and to Mrs. Johnson for their leadership in GME and this whole area, which is critically important to academic health centers.

I am Leslie Cutler. I am chancellor and provost for health affairs at the University of Connecticut Health Center. The Health Center has a medical school, a dental school, other health professions and graduate schools and its own teaching hospital and an integrated network of seven teaching hospitals to facilitate medical education. These hospitals have been organized as the Capital Area Health Consortium from several years.

We have heard from many of the other speakers about the changes in the health care workforce and the way the delivery of health care is moving out of hospitals and into ambulatory settings. A recent report from the Kaiser Health Plan of California indicates that at the end of the eighties and in the early nineties, the average Kaiser patient was in the hospital for care once every 7 years. By the year 2004, they are predicting the average Kaiser patient will only need to be hospitalized once every 16 years.

This does not mean that there will be less care, but the care delivered will be delivered in outpatient arenas rather than in the hospital.

The first chart shows two things: First, it shows you the obvious complexity of the payment system for graduate medical education. Second, the chart makes some important points. Medicare and Medicaid are the only payers of graduate medical education in the country. That is, we pay for graduate medical education with payments from the sick, poor, and the infirm, old. Virtually all the funds that are provided by these governmental sources flow directly to teaching hospitals and then, only on the fee-for-service patients.

Also the amount of the direct and indirect medical education payments received by the hospitals are directly linked to the number of residents in training. As other speakers have said, that provides an incentive to increase the number of residents.

There are other charts that could be put up, but they only reiterate what others have already said. They summarize some of the major changes in the delivery of health care, and correlate these changes and revisions in the education of the residents. They highlight needed revisions in the way GME is funded to achieve the desired outcomes. But, the most important factor is the shift to primary care medicine, and we all realize that primary care medicine

is not delivered in the hospitals. But, the GME funds flow only to hospitals. Similarly, even within medical specialty practice, more and more of the care is being delivered in outpatient sites. Therefore, funds that now flow only to hospitals must also be distributed to support training in ambulatory settings.

In addition, the trend toward managed care has created a dramatic change for academic medical centers. Current education paradigms do not focus as intently as they might on insuring the new generations of health care practitioners are educated to practice medicine in a manner compatible with the best principles of managed care. The cost of reegineering this entire medical education model must be covered from funds outside the traditional reimbursement scheme.

In the future, graduate medical education will involve many players beyond the traditional teaching hospital. Therefore, additional recipients of both direct and indirect medical education payments must be considered. The medical education consortium can be defined as an association of teaching hospitals, academic medical centers, ambulatory clinics, physician practices and other organizations including HMOs and insurers involved in medical care and medical education. Such a consortium can provide a structure to ensure the continuity of education and to develop centralized support for the direction and coordination of its members.

I would like to note that, our Capital Area Health Consortium has for several years served the paymaster and personnel functions for many of our integrated residency programs. Our consortium has served as a vehicle for planning and organizing many of our joint graduate medical education programs and, as we expand this consortium, we are bringing a continuum of care experience that involves family practice and other residents as well as medical students in a variety of curriculum alterations in our school of medicine. Many of these changes and the movement to ambulatory sites are not covered for graduate education by current graduate education payments.

Funding for consortium could come via shared responsibility funds from Medicare. However, given the value of medical education to all participants in the health care system, as well as the importance for ensuring the adequate funding of the special missions of academic health centers and teaching hospitals, it is clear that some new form of payment to finance the special costs incurred in these teaching institutions is appropriate. Such a payment system might include funding from all payers, health plan and insurance premium assessments, provider assessments, general revenue, and specific assessments on activities that raise health risks. Such payments could not only provide needed funds, but also help ease the financial burden carried solely by the Medicare systems graduate medical education funds currently included in capitation payments made through insurers offering Medicare or Medicaid managed care programs, should be withheld and returned to a pool specifically designated for graduate medical education. Payments for graduate medical education should be available to consortia. Whenever possible, a school of medicine should play a role in leading the consortium since education rather

than the provision of service should be the focus of graduate medical education programs.

Transitional replacement fundings needs to be made available to those teaching hospitals that hospitals that lost funding. It is interesting that the Medicare Preservation Act had several positive components that facilitated this mission: the trust fund that included funding from other sources than Medicare, consortia authority, decreased training for specialists and a moratorium on new residents, all of which will facilitate graduate medical education.

I would like to thank the Chairman and Ms. Johnson for the opportunity to talk to the Subcommittee and I am here to answer questions.

[The prepared statement and attachments follow:]

STATEMENT OF
LESLIE S. CUTLER, D.D.S., PH.D.
UNIVERSITY OF CONNECTICUT HEALTH CENTER

Mr. Chairman and members of the Committee, I am Leslie S. Cutler, Chancellor and Provost for Health Affairs at the University of Connecticut Health Center. I welcome the opportunity to comment at this hearing on Medicare's financing of Graduate Medical Education (GME). The University of Connecticut Health Center is an academic medical center with a medical school, other health professions and graduate schools, its own teaching hospital, and an intimately integrated network of seven community teaching hospitals which facilitate both undergraduate and graduate medical education. These teaching hospitals have been organized in the "Capitol Area Health Consortium" for several years.

It is not necessary to underscore to this group the dramatic changes that are occurring in both the delivery and financing of health care across our nation. The reports by the Pew Health Professions Commission and the Institute of Medicine on the size and composition of the country's health care workforce have emphasized the need for enhancing our primary care capabilities while reducing the number of medical specialists and subspecialists. At the same time, advances in science, medical technology and the expansion of managed care have facilitated the movement of substantial amounts of medical care from the hospital to ambulatory settings. In addition, these factors have helped reduce the length of time individuals must spend in the hospital should they require inpatient care. Indeed, a recent report from the Kaiser health system in California indicated that in 1990 the average Kaiser member (there are about 4.5 million in California) required hospitalization for medical care once every seven years. With the improved utilization of primary care physicians, the introduction of prevention and wellness programs, and the ability to deliver increased amounts of care in ambulatory settings, Kaiser predicts that shortly after the turn of the century their average member will only need hospital-based care once every 16 years. This does not mean that there will be less medical care delivered but rather that the bulk of the care provided will occur in outpatient sites. It also suggests that, in the future, when someone does enter a hospital they will be more acutely ill and require highly specialized and very intense levels of care.

The recent report on the solvency of the Medicare Trust Fund points out the challenges the country faces in financing health care. The way in which the nation chooses to solve the dilemmas in financing Medicare, in particular, and health care, in general, will have a substantial impact on our ability to educate the workforce that will provide the care we, as a nation, both need and demand. This is the case because the choices we make will have significant implications for the way that undergraduate and graduate medical education are funded.

This chart shows the way Medicare currently funds graduate medical education. Aside from the obvious complexity, I would like to make three key points regarding the funding of GME: 1) currently, there are only two sources of funds to support graduate medical education: the Medicare program, and in most states, Medicaid programs. While everyone benefits from, and demands, the presence of a high quality medical workforce, only governmental payments related to the sick elderly and the infirm poor support the education and development of that workforce, 2) virtually all of the funds provided by these governmental sources flow directly to teaching hospitals which have traditionally done a superb job of educating graduate physicians as well as providing clinical research, highly specialized care for the sickest of patients, technical advances, and the lion's share of care for those less fortunate in our society, and 3) the amount of the direct medical education payment received by the hospitals is linked to the numbers of residents in service while the indirect medical education payment is tied to the number of residents per bed in the hospital. Both of these payment formulas tie graduate medical education to the inpatient setting and are structured to provide incentives to increase the number of residents in training. At the same time, while there is some reimbursement for training in hospital based ambulatory care settings, there is virtually no payment for training in outpatient settings provided by organizations other than hospitals.

The next chart shows four major trends in the delivery of health care. First, there is a reduction in the need for the number of medical specialists and subspecialists coupled with an increased need for primary care practitioners. Second, there is a trend to decrease the amount of care which requires hospitalization and there is a concomitant increase in the amount and types of care which can be delivered in ambulatory settings. Third, there is a reduction in the length of time patients spend in the hospital, for even the most serious medical problems. This decrease in the time spent in the hospital is correlated with our increased ability to deal with patients in lower cost transitional/subacute care and homecare settings. The fourth trend is the continuing

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constriction of the reimbursement for health care services. There is a movement away from the traditional fee-for-service type payment and movement towards managed care and capitation, both in Medicare and Medicaid as well as in the private sector.

The final chart summarizes the changes we must make in the way we educate the medical workforce that logically follow the evolving trends in the health care marketplace. These changes are correlated with needed revisions in the way we fund graduate medical education in order to appropriately achieve the desired outcomes. First, primary care medicine is not delivered in the hospital. The increased emphasis on primary care over specialty medicine leads to a need for increased training in ambulatory settings and a reduction of training in hospital venues. Therefore, funds that now flow only to hospitals must also be distributed in a way that supports training in ambulatory sites. Similarly, even within medical specialty practice, more and more of the care will be delivered in ambulatory sites and surgicenters rather than in the hospital. Thus, a portion of the funds targeted for specialty training must be available for training and education in outpatient centers. Correlated with the reduction in inpatient length of stay is the need for increased education and training in transitional/subacute care sites. Finally, the trend towards medical practice, which is of high quality but cost-effective within the managed care context, requires a revamping of both the undergraduate and graduate medical educational experience. Current educational paradigms do not focus as intently as they might on the mechanisms for insuring that the new generations of health care providers are educated to practice medicine in a manner compatible with the best principles of managed care. The cost of this reengineering of the medical education model must be covered by funds outside the traditional reimbursement schemes.

The requisite changes in both undergraduate and graduate medical education will involve many players beyond the traditional teaching hospital. Therefore, a new, or additional, focus as a recipient of both direct and indirect medical education payments must be considered. The Medical Education Consortium (MEC) provides such a structure. A MEC could be defined as an association of teaching hospitals, academic health centers with their medical and other health professions schools, ambulatory clinics, physician practices (individual or group), and other organizations involved or with interest in medical education. Such consortia could provide enhanced mechanisms to assure the continuity of medical education and to develop centralized support, direction, and coordination for its members so that they function collectively to meet the challenges and changing needs of the community as well as nation's health care system. I would like to note that our "Capitol Area Health Consortium" has, for several years, served a paymaster and personnel function for our many integrated residency programs. The "Consortium" has also served as a vehicle for planning and organizing many of our residency programs. The positive, cooperative interaction, within our consortium, to facilitate area wide planning and coordination of graduate medical education and other health care delivery issues demonstrates the value of such consortia. These consortia need to include a broader array of members and the funding of GME needs to support education at all of these sites.

The quality of the educational programs within the consortia should be under the leadership of the Accreditation Council for Graduate Medical Education and the consortia's academic health center/medical school (if one were available). Residencies, which were primarily service-oriented, would need to be a redesigned to primarily address the educational needs of the trainees. Funding for such consortia could come from a "shared responsibility" fund from Medicare. However, given the value of medical education to all participants in the health care system as well as the importance of insuring adequate and stable funding for the special missions and activities of academic health centers and teaching hospitals, it would seem that some new form of payment to finance the special costs incurred by these teaching institutions is appropriate. Such a payment system might include funding from all payers, health plan and insurance premium assessments, provider assessments, general revenue, and specific assessments on activities that raise health risks. Such supplements could not only provide needed funds but also help ease the financial burden currently carried by the Medicare system.

Graduate medical education funds currently included in capitation payments to insurers offering Medicare or Medicaid managed care programs should be withheld and returned to a pool specifically designated for graduate medical education. Payments for graduate medical education should be made to consortia or, if not available, to organizations or entities that incur the costs of the educational programs. For graduate medical education consortia in which multiple

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organizations incur education expenses, the consortia should demonstrate general agreement among the participants on the distribution of the funds. Whenever possible, an academic health center/school of medicine should be included in a consortium and should play a leading role in the consortium since education, rather than the provision of service, should be the focus of a graduate medical education program.

Transitional and replacement funding should be made available to buffer those teaching hospitals that lose funding as existing inpatient residency training positions and programs move to outpatient venues and as education becomes more central to some residency programs. Sudden changes in the number and specialty mix of residents and their sites of training could disrupt the service activities of some teaching hospitals and could have broad effects on both the institutions and the communities they serve. Consideration for provision of a funding source to help such institutions through a transition in workforce composition should be seriously evaluated.

Let me briefly mention the importance and value of schools of medicine in providing the educational leadership that develops both undergraduate and graduate physicians. Focus on graduate medical education alone ignores the costs and needs of the institutions that educate those who will become "graduate medical trainees" we are discussing today. Please be aware that there is essentially no federal, and only limited state, support for undergraduate medical education. Keep in mind that the development of the pool of medical graduates that is the focus of this session, is funded largely through tuition and the provision of resources generated by the practice of medicine in ambulatory and hospital venues by the schools' faculty. A national fund should be established to assure adequate and stable funding for the special missions and activities of medical schools. Such a fund will be critical for most medical schools to remain fiscally viable and to fulfill their primary missions of education and research. These missions are increasingly under pressure as the marketplace eliminates the margins derived from the schools' clinical enterprise which serve to subsidize the academic mission. Since all of us ultimately benefit from the development of a high quality health care delivery workforce, this fund should come from assessments to all payers, health plan and insurance premiums, general revenues and other mechanisms such as specific taxes on activities that raise individual or group health risks.

I would like to thank the chairman and the committee for their efforts in this extraordinary task of designing a system to support graduate medical education. The academic medical community appreciates your efforts and stands ready to work with you on ways to strengthen the Medicare program and to insure that the nation's health care system continues to provide the best care in the world.

Payment for Graduate Medical Education

Current Direct GME Payment Methodology

Step 1: Calculate hospital-specific per resident amount using FY1984 or 1985 costs and base year number of residents

Step 2: Update base-year per resident amount for inflation

Step 3: Multiply the updated per resident amount by the number of residents in the payment (current) year

Step 4: Determine Medicare's share based on proportion of program's inpatient days

Computing a Hospital's Direct GME Payment

Payment Year Characteristics

• Residents in primary care specialties	=	55 FTEs
• Residents in non-primary care specialties in the initial residency period	=	135 FTEs
• Residents beyond period of initial board eligibility	=	60 FTEs
• Total Number of Residents		250 FTEs
• Medicare's Share of Inpatient Days		30%

Step 1:

• Based on 1984 or 1985 costs and base year number of residents

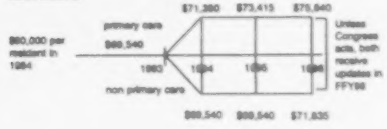
(Historical Audited Costs/Number of FTE Residents)

($10,000,000/200 FTEs) = $50,000 per resident amount

Step 2:

Update using percentage change in CPI-U

For FFY 94 and 95, inflation update applies only to primary care residents



Step 3:

• Two calculations: Primary Care (PC) and Non-Primary Care (NPC) Residents

A. (PC Per Resident Amount* Number of FTE PC Residents)
($75,640* 55 PC Residents) = $4,171,200

B. (NPC Per Resident Amount* Number of FTE NPC Residents)
($71,835* 135 NPC residents) + $71,835* (60* .5)) =$11,852,775)

C. Determine PC and NPC Aggregate Amount
$4,171,200 + $11,852,775 = $16,023,975

Step 4:

Medicare Inpatient Days = 30,000
Total Inpatient Days = 100,000
Medicare's Share = 30,000/100,000 = 30%

Aggregate * DGME Amt	Medicare's Share	= Direct GME payment
$16,023,975 *	30%	= $4,807,193

Current IME Payment Methodology

Step 1: Determine your hospital's resident-to-bed ratio (IRB).

Step 2: Insert your hospital's IRB into formula.

Step 3: Calculate the IME payment.

Indirect Medical Education (IME) Adjustment

• Percentage add-on payment to basic DRG payment.

• Compensates teaching hospitals for higher inpatient operating costs due to:

- severity/DRG weaknesses
- operating costs associated with education programs

• Based on statistical analysis using intern and resident-to-bed ratios (IRB)

• Current level is 7.7% for every 10% increment in IRB

• 1,081 hospitals receive $4.3 billion in FFY96

Step 1:

Calculate IRB by dividing interns and residents FTE count by number of PPS beds.

eg: IRB = 150 FTE ÷ 500 beds = .30

Step 2:

Insert result from step 1 into IME formula.

IME % add on = $[1.89 (1+IRB)^{.405}-1] 100$

21.19% = $[1.89 (1+.30)^{.405}-1] 100$

Step 3:

Apply percentage from step 2 to DRG payments.

Assume payment for DRG 106 = $23,228

IME payment = ($23,228 x 21.19%) = $4,922

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Trends In Health Care Delivery

- ↓ Specialists
- ↓ Inpatient Care
- ↓ Inpatient Stay
- ↓ Payment & ↓ Fee-For-Service

- ↑ Primary Care
- ↑ Ambulatory Care
- ↑ Transitional & Home Care
- ↑ Managed Care (Private sector & Medicare & Medicaid)

Changes Needed in the Funding of GME

- Decrease specialist training in total and increase primary care and specialist training in ambulatory sites
- Make funds available for training in ambulatory sites. Fund ambulatory training sites in addition to hospitals
- Ambulatory sites include clinics, surgicenters, physician offices, group practices
- Support Medical Education Consortia (MEC) - hospitals, AHCs, clinics, physician offices, surgicenters, etc.
- Education trust fund is required

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Chairman THOMAS. Thank you very much.

[The introductory statement of Hon. John Ensign follows:]

I am pleased to welcome Dr. Anthony Marlon, Chief Executive Officer and Director of Sierra Health Services, as a distinguished witness before the Ways and Means Health Subcommittee. He is accompanied today by Dr. Jerry Reeves, Senior vice President, Health Care Operations at Sierra. Dr. Marlon and Sierra represent some of the most creative and innovative thinking in the health care market today.

I would also like to mention the other half of this creative partnership, the University of Nevada School of Medicine (UMC) lead by Dean Robert Daugherty, who could not be here today.

In 1994, UMC and Sierra undertook the process of creating a teaching HMO. Based on the model of the Harvard Community Health Plan, UMC and Sierra developed a program wherein internal medicine residents were integrated into the patient care activities of the plan.

In the summer of 1995, the program was expanded into the outpatient setting. Residents were assigned to one of the HMOs ambulatory sites, saw patients under the supervision of an HMO-employed physician and/or a faculty member assigned to the HMO and, when necessary, follow those patients into the hospital on the HMO's service.

The UMC/Sierra partnership addresses a major shortcoming of current graduate medical education, namely, that the teaching hospital may not always be the best setting for much of graduate medical education. Experts indicate that, on average, American physicians spend over two-thirds of their professional time with patients in an ambulatory setting, much of this on primary care activities.

I believe that the UMC/Sierra model is one that could function as a demonstration project to gather information for other similar models functioning nationwide. This model would be an effective way to collect more information on how public funding could be used to allow ambulatory care settings to be reimbursed for the cost of training apprentice physicians

As we work to continue the task of saving the Medicare system, we must ensure that graduate medical education funding is concentrated in those areas or training programs that are the most cost-effective and accurately address the educational needs of tomorrow's physician.

I am proud to introduce Dr. Marlon who, along with Dean Daugherty of the medical school, have implemented a common sense plan for teaching future physicians in a manner that is advantageous to the student, the school, the health care market, and that which is ultimately best for the patient and the Medicare system.

Chairman THOMAS. Dr. Marlon.

STATEMENT OF ANTHONY M. MARLON, M.D., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, SIERRA HEALTH SERVICES, INC., LAS VEGAS, NEVADA; ACCOMPANIED BY JERRY REEVES, SENIOR VICE PRESIDENT, HEALTH CARE OPERATIONS, SIERRA HEALTH SERVICES, INC., LAS VEGAS, NEVADA

Dr. MARLON. Good afternoon, Mr. Chairman and I would like to thank John Ensign for his kind words. I certainly appreciate the opportunity to speak with you today regarding Medicare financing of graduate medical education.

I am a cardiologist and I am chief executive officer and chairman of the board of Sierra Health Services. With me is Dr. Jerry Reeves, who is a pediatric hematologist oncologist. Dr. Reeves is also Senior Vice President of Health Care Operations at Sierra and is an Associate Dean at the University of Nevada School of Medicine.

In the interest of brevity, I will present only a summary of our testimony but request that our entire statement be accepted into the record.

Sierra Health Services is a publicly traded company that finances, arranges and delivers quality health care to more than a half million people in eight states. We have approximately 2500

employees and we are based in Las Vegas, Nevada. Our wholly owned subsidiaries include the Health Plan of Nevada, the state's largest health maintenance organization and Southwest Medical Associates, the state's largest multispecialty medical group.

The purpose of our comments today is to affirm our commitment to the education of physicians and medical students to successfully meet the needs of delivering medical in the 21st century through a public-private partnership. Medical care in the United States today is shifting, as we have heard, toward ambulatory and office-based care. Even the Residency Review Committee which set the accreditation criteria for residency training programs, have begun to require more outpatient training.

These requirements follow a report from the Council on graduate medical education to Congress which contains suggestions on how to correct the mismatch between the physician work force and the health care system demands. Unfortunately, the funding streams supporting medical education have not shifted to reflect these changing patterns.

We believe future funding should be available to support medical education partnerships between medical schools and HMOs that provide ambulatory primary care training that emphasizes early intervention, preventive services and team-based coordinated care. We are experiencing a paradigm shift in health care from fee-for-service to coordinated care, from institutional care to office and clinic-based care.

The goal is to provide quality, coordinated health care services to patients in order to obtain optimum outcomes, whether it be in the home, the community health center, the doctor's office or the hospital. Integrated care teams supported by information systems provide this coordinated care. These teams need leaders and this is our challenge. How do we educate these leaders and how do we pay for it?

In addressing these changes in our environment, I would like to describe to you the relationship between our publicly traded company and our state-funded medical school.

We at Sierra have had more than a decade long tradition of providing teaching services and clinic practice opportunities for the University of Nevada School of Medicine. Initially, most of this teaching took place in a hospital setting. In 1994, the school of medicine and Sierra expanded a program to integrate internal medicine residents into the full spectrum of patient care activities provided by the health plan of Nevada.

Currently, Sierra and the school of medicine are engaged in a pilot program in which revenues from private patients are used to help fund the education of residents. Continuity of care is emphasized throughout the 3-year training program. A coordinated care curriculum is added to the traditional academic, internal medicine education curriculum. Residency requirements for expanded outpatient care are satisfied and an alternative source is developed for some of the funding.

The integrated training in ambulatory coordinated care and internal medicine is now expanding in Nevada to include family practice residents, medical students and physician assistant trainees. Nevertheless, the primary challenge to long term success will al-

ways be a portion of unreimbursed cost of medical education. While costs may be less for primary care, they will indeed be more for certain non-primary care specialties and for medical students. It appears easier to us to integrate primary care resident training into the health plans than to integrate the non-primary, often hospital-based specialties.

In conclusion, I would like to reiterate that, I believe publicly traded companies like Sierra have an obligation and a responsibility to assist in the training of future physicians. I believe it does happen across this country.

I believe also that Federal funds should continue, but should no longer be allocated only to hospitals. Federal funds should be available for graduate medical education where it is taking place, whether it be in HMOs, in teaching hospitals or in teaching community health centers.

Finally, we are prepared to offer the Sierra and University of Nevada School of Medicine model as a site to study and define the direct and indirect costs of medical education in a public-private partnership in an HMO setting.

That concludes my testimony, Mr. Chairman and I appreciate the opportunity.

[The prepared statement follows:]

STATEMENT OF
ANTHONY M. MARLON, M.D.
SIERRA HEALTH SERVICES, INC.

Good afternoon Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to speak with you today regarding Medicare financing of Graduate Medical Education. My name is Anthony Marlon. I am a cardiologist and CEO and Chairman of the Board of Sierra Health Services. Accompanying me is Dr. Jerry Reeves, who is a pediatric hematologist/oncologist. Dr. Reeves is Senior Vice President of Health Care Operations at Sierra, and is also an Associate Dean at the University of Nevada School of Medicine.

Sierra Health Services is a publicly-traded company that finances, arranges, and delivers quality health care to more than 500,000 people in eight states which has entered into a public-private partnership with the University of Nevada School of Medicine to prepare medical graduates for the changing health care delivery system. We have approximately 2500 employees, and we are based in Las Vegas, Nevada. Our wholly owned subsidiaries include the state's largest health maintenance organization and the state's largest multi-specialty medical group practice. Health Plan of Nevada, a federally-qualified HMO, currently has approximately 117,000 non-Medicare enrollees (representing more than 49% of the state's non-Medicare HMO enrollment) and 27,000 Medicare risk HMO members (representing more than 50% of the state's Medicare population enrolled in HMOs). Southwest Medical Associates, the medical group, has 140 medical providers in 12 locations. These providers, who practice in more than 20 specialties, provide services in our clinics, ambulatory surgery center, and 24-hour urgent care facility as well as in affiliated tertiary care hospitals and subacute care facilities.

The purpose of our comments today is to affirm our commitment to the education of physicians and medical students to successfully meet the needs of delivering medical care in the 21st century through a public-private partnership.

Medical care in the United States today is shifting towards ambulatory, office-based care. The old approach focused on delivering often wasteful high- tech, specialized, invasive hospital-based care. The new approach emphasizes early access to evaluation and treatment by primary care provider health teams in less restrictive environments. The combination of these early interventions along with ongoing preventive health care services often result in improved health care outcomes and higher patient satisfaction.

A number of major social and political forces have converged simultaneously to influence -- and change dramatically -- the structure of medical education. Foremost among these forces is the more than 130 million Americans enrolled in health plans.

Second, increasing enrollment in health plans demands an increased number of primary care physicians and allied health providers and a decrease in the number of specialists. Some anticipate that the current ratio of 20% generalists to 80% specialists will need to be reversed by the year 2020. If current trends continue, the Council on Graduate Medical Education predicts in the year 2000, a surplus of 125,000 specialists and a modest shortage of 20,000 generalist physicians in an increasingly health care network-based system.

Third, in response to these changes, the Residency Review Committees, which set the accreditation criteria for residency training programs, have begun to require that up to 50% of the training time of residents be spent in an outpatient setting. These recommendations follow a report from the Council on Graduate Medical Education to Congress that contains suggestions to correct the mismatch between the physician work force and health care system demands.

Unfortunately, the funding streams supporting medical education have not shifted to reflect these changing patterns. Today, postgraduate medical education funding remains focused on hospital-based training. We need to redeploy funding of medical training programs for medical students and residents to ambulatory sites where they are most needed. We believe future funding should be available to support medical education partnerships between medical schools and health care organizations that provide ambulatory primary care training that emphasize early intervention, preventive services, and team-based coordinated care.

We are experiencing a paradigm shift in health care from fee-for-service to coordinated

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care, from institutional care to office and clinic-based care. The goal is to provide quality, coordinated health care services to patients in order to attain optimum outcomes, whether it is in the home, the community health center, the doctor's office, or the hospital. Integrated care teams supported by information systems provide this coordinated care. These teams need leaders. That is our challenge. How do we educate these leaders? How do we pay for it?

In addressing these changes in our environment, I would like to describe to you the relationship between our publicly-traded company and our state medical school. We, at Sierra, have more than a decade-long tradition of providing teaching services and clinical practice opportunities for the University of Nevada School of Medicine. Initially, most of this teaching took place in the hospital setting. In 1994, the School of Medicine and Sierra expanded a program to integrate internal medicine residents into the full spectrum of patient care activities provided by the Health Plan of Nevada. Residents received education and medical services opportunities on our HMO service in the private tertiary hospital where we admitted most of our patients. The costs of training these residents continued to be covered by the hospitals.

Currently, Sierra and the School of Medicine are engaged in a pilot program in which revenues from private patients are used to help fund the education of residents. In 1995, the program expanded into the outpatient setting. Residents were assigned to one of our ambulatory clinic sites. These residents continued to follow their HMO patients throughout the year under the supervision of Southwest Medical Associates employed physicians with clinical faculty appointments at the School of Medicine. Full-time faculty members of the School of Medicine assist with supervision and teaching of residents.

Two affiliated teaching hospitals, the affiliated subacute hospital, and our outpatient clinic provide continuity of care training experiences which is emphasized throughout the three year training program. Residency requirements for expanded outpatient care are satisfied and an alternative source is developed for some of the funding. At any given time, residents care for hospitalized HMO patients, evaluate and treat outpatient clinic patients, and serve subacute care unit patients. A coordinated care curriculum is added to the traditional academic internal medicine education curriculum, preparing graduates to succeed in health plans after graduation. It includes:

- fostering health promotion and disease prevention services;
- communicating effectively with patients and panels of patients;
- effective detection, diagnosis, and management of common symptoms and physical signs;
- management of common acute and chronic medical conditions;
- understanding and practicing the principles of effective quality improvement;
- coordination of all aspects of care, including referral to other specialists, and the appropriate use of technology;
- detection, understanding, and management of health risk problems;
- demonstration of leadership and team building skills, including appropriate resource utilization;
- the use of clinical and management information systems to analyze and improve practice and outcomes patterns;
- understanding and engaging in decision making with patients, families, and other providers; and
- applying knowledge of coordinated care systems in evaluating and applying advances in the medical literature.

The integrated training in ambulatory coordinated care in internal medicine is now expanding to include family practice residents, medical students, and physician assistant trainees.

Although we have experienced some of the anticipated pressures between the School of Medicine academic culture and health plan culture, we are finding that by building on our base of mutual trust and respect, mutual benefits, and commitment from the top, we are overcoming

the potential clash of organizational cultures. However, unreimbursed medical education costs remain an issue.

The federal government has long recognized the cost of medical education and teaching of physicians. In our competitive marketplace, it is unreasonable to assume that health care organizations can succeed for the long term if their real costs exceed those of their competitors. Failure to address this cost disadvantage can threaten the viability of such relationships on a going forward basis.

For example, in our primary care clinic staffed by salaried physicians, we calculate the direct salary cost of precepting two medical students for a 20-week rotation to total $30,000. The salary cost for an internist to oversee two part-time medical students and three part-time residents weekly for a year totals more than $110,000 in our tightly managed outpatient clinic setting. These do not include overhead costs for support personnel, facilities, equipment, and information systems. Some of these costs can be supported by patient-generated revenues.

Nevertheless, the primary challenge to long term success will always be the unreimbursed cost of medical education. While costs may be somewhat less for primary care, they will indeed be more for non-primary care specialties and medical students. It appears easier to integrate primary care residency training into health plans than to integrate non-primary, often hospital-based, specialties.

In conclusion, I would like to reiterate that I believe that publicly traded companies, like Sierra, have an obligation and responsibility to assist in the training of future physicians. I believe also that federal funds should continue, but should no longer be allocated only to hospitals. Federal funds which are available for graduate medical education should fund education where it is taking place -- in teaching HMOs, in teaching hospitals, or in teaching community health centers.

Finally, we are prepared to offer the Sierra and University model in Nevada as a site to study and define the direct and indirect costs of medical education in a public-private partnership in an HMO setting.

That concludes my testimony, Mr. Chairman. We would be happy to answer any questions which you or any other Members may have.

Chairman THOMAS. Thank you very much.

Dr. Reeves, do you have any testimony?

Dr. REEVES. My comments are his.

Chairman THOMAS. Good. The gentlewoman from Connecticut, do you wish to inquire?

Mrs. JOHNSON. Thank you, Mr. Chairman.

Dr. Cutler and Dr. Marlon, do you feel that you have sufficient authority in the law to develop consortium relationships that will enable you to reimburse the diverse kinds of training sites that are necessary to train physicians for the future?

Dr. CUTLER. Under the current law?

Mrs. JOHNSON. Right.

Dr. CUTLER. No. We would like that authority. From our perspective, we would like to see the facilitation of the kinds of programs that were just talked about.

Mr. MCDERMOTT. Would the gentlelady yield for one specific comment?

Mrs. JOHNSON. Yes.

Dr. CUTLER. From our perspective, we would like to see the funding come to a consortia or to a public-private partnership that would allow us to place residents in partnership with a private entity. We would have to work that out. I do not have the specifics of how that would work at this time, but that would allow us to do training out of the hospital; that would allow us to train our residents, to practice medicine in a way that is conducive to the way medicine will be practiced in 2000.

It is an obligation of academic health centers to train medical students not for today, but for tomorrow. That is where it is going to be. That is where the action is.

Dr. MARLON. I agree wholeheartedly. Under the current law, the money flows to the hospital. As we, in fact, do more of our teaching in whatever the setting is, it is necessary to train these professionals for the future. We in Nevada have determined—have found a funding source from private dollars, from private patient activities to fund some of this. Currently, we cut a check to the university to fund or to pay for what services are performed in the HMO setting.

The revenue currently from Federal funds all still goes to the hospital. There is no way to reimburse Jerry and his subsidiary company for those indirect costs that we are currently bearing and that, for example, may be increased as we move this forward to try to assist more medical students in this kind of an environment or try to expand this to certain specialty training.

Mrs. JOHNSON. But, do you have no right to reimburse non-hospital entities for training costs under current law?

Dr. MARLON. No, under current law, the money goes to the hospitals.

Mrs. JOHNSON. Right, but could the hospital not reimburse a practice for the indirect costs of medical education?

Dr. MARLON. Now, you are entering into a market situation where the hospital then talks to the chief executive officer of a publicly traded company and says, I am going to pay you for the residents that work at your shop.

Mrs. JOHNSON. Well, one possible iteration of a consortium is, the consortium would be the administrative unit of a group of providers that got together to provide the scope of the training that would qualify the residents. It is not necessary to have the hospital the entity that the money flows through. It could conceivably be an entity that was certified by the medical school. Somebody has to certify that this group is capable of providing the training that the residents require, but it need not be necessarily a hospital.

It seems to me, in 10 years, some other group might want to contract with the hospital for this amount of training in this area and this amount in this area and this hospital for subspecialty training in this area and outpatient and geriatric and nursing home and whatever else.

Is there a theory in the law now for someone other than a hospital to be the recipient of the total dollars and allocate them to whomever they have contracted with?

Dr. CUTLER. It is extremely complicated to do anything like that. The idea of a consortium makes that possible because the funding would go to the consortium rather than individual institutions. The consortium would decide where the residents would train and where the dollars flowed. The dollars logically should flow where the costs are borne in terms of that. If a managed care company, whether publicly traded or not, was part of that entity, it would work.

Mrs. JOHNSON. Now, you have succeeded in doing this with a group of hospitals. Do you have the authority to include non-hospitals in your consortium and to reimburse them for cost of training including indirect?

Dr. CUTLER. Not indirect costs, only the direct costs and it is very difficult. It is very complicated and one needs to do all kinds——

Mrs. JOHNSON. The problem is, you cannot train somebody in a practice setting. You are going to slow down the pace at which they see patients, unless you can help them offset the loss of income.

Dr. CUTLER. Absolutely.

Mrs. JOHNSON. Yes, OK.

So, you really do need more authority?

Dr. CUTLER. Yes.

Mrs. JOHNSON. We do need to envision more flexibility as to whom the consortium should be?

Dr. MARLON. You need that change in law.

Our program involves not only the ambulatory care site, not only the in-hospital, but we have subacute and geriatric care that, in fact, is incorporated into the whole gambit. A lot of those things are not covered.

Mrs. JOHNSON. Would a simpler, quicker way to do this be to give every medical graduate a voucher and then he would just use his voucher wherever he would go? Like you get a scholarship, you can use the scholarship at whatever institutions you choose to go to, I mean, some scholarships, not all.

Dr. CUTLER. I am not sure that is the way to drive medical education. When you are talking about undergraduate education where you want to be an English professor, it is like giving everybody a scholarship. You get to choose where the money should flow. It is through a consortium headed by a medical education organization

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that would then ensure quality and the right mix of people and the right mix of training, I think.

Dr. MARLON. The policymakers need to decide how many internal medicine residents you want, how many general surgery, how many cardiology residents.

Mrs. JOHNSON. We cannot decide that. We have never been good at work force planning. We have a hard time even hiring the right people to do the jobs in Federal Government. So, forget that. [Laughter.]

Chairman THOMAS. We do see the wisdom in letting the people choose their representatives, however. [Laughter.]

Mrs. JOHNSON. Look at how rapidly the change in demand in the market is already affecting resident choice. It takes us 5 years to make any appreciable change in law. By the time we made any change in the allocation of slots, it is simply not practical.

Thank you, Mr. Chairman.

Chairman THOMAS. Yes, I am going to go to the gentleman from Washington.

This is one of my real concerns, because I sit here listening and the solution primarily is to scrunch down and to define who gets what, which creates a reward for some people and a denial of others. All of us, I think, agree we need medical education and training, but it is back to by whom, for whom, where.

To a certain extent, if you will take the model of that undergraduate where you have an accrediting institution, but more and more, these accrediting institutions have different profiles. It is very difficult to determine. If you had a voucher in which we freed up the ability to put together a consortium as to what they did and how they did it, you could also then have a little bit of a market determination of who is doing it right. Rather than us picking the model that is going to do it for tomorrow, let tomorrow's doctors pick which models they think work.

Of course, you do not think they have the ability to do that as much as they should. I understand that, because we would limit it in part by accreditation and examination. Short of that kind of fairly revolutionary thinking in terms of who gets what, when and how in medical education, we are not going to solve the problem.

The gentleman from Washington.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

The most interesting person at this table has not said anything yet, so I am going to ask him. Dr. Reeves, tell me—it seems to me that you live in about three different worlds. You are working for Sierra. You are a medical school dean and you are also related to one of the attendant companies to Sierra. Can you explain your relationship, how you operate in those various capacities?

Dr. REEVES. Yes, sir, I appreciate the opportunity to testify and thank you very much.

Mr. MCDERMOTT. I am asking this, because Dr. Cutler says you cannot integrate managed care into a State medical school. Yet, some way or the other, they got their arms around you.

Dr. REEVES. I will give the answer by example of what we are doing in our particular partnership. The University of Nevada School of Medicine and Sierra have come together to provide integrated training in primary care. We have done it by setting up

what you would call a consortium in the earlier discussion, that is, a governance group that says, we are going to agree to do this together.

There are cultural clashes that relate to the culture of care coordination, the private company and the academic world. However, we have found that, by commitment from the top, namely Dr. Marlon's commitment as chief executive officer of Sierra Health Services, Dr. Doherty's commitment as dean of the medical school, my commitment from the health care delivery, my responsibilities within Sierra are all of the health care delivery entities as opposed to the insurance side.

By bringing that group together and mapping our strategy for how to integrate our activities, we have found that we can meet the educational goals. We can prepare graduating residents to work better in my medical group practice, Southwest Medical Associates we mentioned and can do it more effectively from the minute they start, rather than the significant training costs that we had to incur to bring them up to speed to practice successfully in our managed care environment based on their abilities graduating from the existing models of medical education.

I am going to now wear three hats. I am going to talk about the hat that I wear as president of the medical group practice.

I am now getting graduates who enter our program as practicing physicians who I do not have to spend 6 months of training at learning how to practice efficient care and coordinate it in a team-based approach with placing a patient in the least restrictive environment. That was a real cost we were bearing. I also decreased my real cost in what——

Mr. MCDERMOTT. Give the Subcommittee some understanding of what it is you had to train out of the previous medical graduates.

Dr. REEVES. When residents graduate from medical schools and from residency programs, they tend to have had hospital-based, ICU training where you order everything in the book just in case the professor may ask. You really are not trained in a mode of, if you did not do this, so what. It takes a while to change that modus operandi to this different approach and it is a day in, day out thing that is very, very frequent in the outpatient setting and becomes less important and, therefore, is less incentivized in the hospital setting.

So, there is real cost to that, that we were bearing from their ordering a lot of unnecessary things that had no impact on achieving our goals of the patient satisfying health improvement. We would go through an elaborate training curriculum for these new graduates who come into our faculty to get up to speed to accomplish these kinds of patterns of practice through feedback. It takes administrative overhead to generate the reports, to drive those kinds of behaviors.

The other major cost that we have minimized is the recruiting costs, because these residents who have trained with us in this setting tend to want to stay in that setting. They feel comfortable there. It is the right way to practice, in their view. It is something that they want. So, that has been the offsetting benefit to us. Plus, we believe it has enhanced the quality of the practice that our providers are delivering.

Now, from the medical school point of view, they have gotten another source of funding for residents. We pay the medical school, the medical group.

Now, I am going to take my hat as the associate dean of the medical school, receiving a payment from myself as president of the medical group.

We pay, from Sierra Health Services' funds through the Southwest Medical Associates, which is the multispecialty medical group practice with 12 sites in Las Vegas. We pay the medical school per patient seen for patients that the residents see in our outpatient clinic setting. These patients are empaneled to that resident plus his supervising attending physician, who is a Southwest Medical Associates physician. That patient continues to see that doctor who is a resident in internal medicine for the 3 years that that internal medicine resident is there.

That patient perceives that resident as being his or her doctor, backed up by the attending physician who is the supervising teaching physician.

We, Southwest Medical Associates, pay the medical school so many dollars per patient seen for the care given by that resident, which is an adjustment factor. The fact that that panel of that particular physician can be a larger panel if that physician is supervising two residents and the three of them are seeing patients in the clinic rather than just that one physician seeing patients in the clinic.

So, even in a prepaid, managed care environment, where 90 percent of our revenues come from prepaid patient care, managed care revenues, there is a way to cover our direct costs for much of what the residents do. There are still inefficiencies and that is why we are testifying today. You cannot totally recover from that. It relates to the teaching mission. It relates to some of the patterns it takes until they get fully efficient. It relates to the administrative overhead for coordinating these programs. There are some real education costs, but some of those, as far as the medical school is concerned, are helping them with an additional stream of revenues for the training programs in primary care.

Mr. MCDERMOTT. Since you get a continuous flow of physicians who you have acculturated going right into your Sierra Services, why don't you, Dr. Reeves, dean of the medical school, charge Sierra's Dr. Reeves more for the training that the medical students have gotten? You have essentially trained them. Sierra does not have to go out around through the community and try and guess what doctor is any good. They know who is good. So, why don't you charge Sierra more? Sierra is ultimately going to reap the benefit. It is a privately funded stock company.

Dr. REEVES. Well, I am not sure I understand the flow. Maybe Dr. Marlon can answer that.

Dr. MARLON. The question is, we already have paid for it. There is no possible way that within this public-private partnership, we can identify certain direct costs. We have some revenues flowing from the company back to the medical school, but the commitment, Jerry's commitment, my commitment, the staff commitment can never be repaid in its entirety. That is a tradeoff.

We get well-qualified, trained physicians in return for a commitment that we make to the training process and the time that we spend that is, in fact, never compensated for.

Mr. MCDERMOTT. Is there any other——

Chairman THOMAS. The gentleman's time is expiring.

Mr. MCDERMOTT. Thank you. One last question.

Is there any other medical school that you know of that has the kind of relationship you have developed with a managed care operation? I ask the question of the doctor from New York, from Montefiore. Is there any other hospital or any other medical school and HMO that you know of that has this kind of relationship?

Dr. REEVES. After a fashion. Our particular combination is a private HMO with a state medical school, which is much more generalizable in this nation than would be the not-for-profit institution, like Harvard Community Health Plan or Henry Ford Hospital System, that is predominantly hospital-based or predominantly medical school-based and they have added an HMO into their system. That is not as generalizable as ours.

To my knowledge, there are not other combinations of our particular combination that have experience yet. There are several who we have been contacted by to talk with them, to assist them with setting these up. As far as actual operational experience yet, I am not aware of them yet.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Dr. Jacott wanted to respond.

Dr. JACOTT. Yes. We have an arrangement at Minnesota that is not quite like yours, but within our department of family practice, we have our own HMO. That was developed as a Medicaid managed care product, based on a waiver that you granted to our state. That HMO provides revenues for our department, for the training in our—we have seven clinics where we train family physicians. It provides revenue, but it also teaches our family physicians managed care techniques.

Mr. MCDERMOTT. Mr. Chairman, I would make a distinction—maybe you do not—between a for-profit HMO's relationship to a medical school and what are essentially not-for-profit HMOs associated with a medical school that developed internally. This was not developed internally. This was an external graft by an HMO on to a medical school.

So, for some financial reason, you decided to split off this HMO and set it up. Is that fair to say?

Dr. JACOTT. Well, yes, that is correct. That is why I say it is not exactly like theirs, but it is a variation of using managed care to support medical education.

Chairman THOMAS. Your model is far more common. This one is, I think, relatively unique.

Mr. MCDERMOTT. This is more common.

Chairman THOMAS. That is a more common approach in terms of a structure.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Yes, thank you, Mr. Chairman. You can see why I am proud of this company and many other innovative things to come out of the great State of Nevada.

Anyway, tell the gentleman that he ought to caution these folks when the gentleman from Washington indicated he thought they should pay more, because take a look at taxation on dividends under our current personal corporate income tax structure if you do not think you can get hit twice. [Laughter.]

I have a couple of questions. First of all, how do you determine how many residents you are going to have in this area, Dr. Marlon? How do you determine how many residents with the university you would determine to go into what fields?

Dr. MARLON. What we tried to do when we started this was, integrate, fully integrate the department of medicine. The ultimate strategic vision was that the department of medicine at the HMO and the department of medicine at the medical school should be fully integrated and be essentially one department. Under those responsibilities or division of labor, the HMO is responsible for marketing and patient generation and the economic side of it. The medical school was responsible for the teaching mission. Then it was our job to make sure this thing paid for itself.

We did that in a way that is commensurate, in terms of numbers, with the number of residents that the medical school currently had under its auspices in internal medicine, what we thought we could handle legitimately inside of our system dealing with the capacity. We are responsible to generate the patient flow, not only the Medicaid patient flow, but Medicare and commercial patient flow into this kind of a system.

So, it was a market-driven decision in terms of the number. We currently have about—let me turn this over to Jerry—but, it is about 18.

Dr. REEVES. Right. We right now have 18 residents. On any given day, there are nine residents that are working in our outpatient unit at Southwest Medical Associates, one who is at the subacute care facility and eight who are at the hospital.

Mr. ENSIGN. The point of my question is, we talked earlier about—and Dr. Cutler responded also about—determining or having policymakers determine the number of residents in internal medicine and in surgery. My point was to ask the question and you answered it just the way I thought you would answer it. The market determined that.

I sometimes get back to veterinary medicine, because it is a really good model in a lot of ways of how the market determines. How many surgeons are there going to be? How many ophthalmologists there are going to be. The market determines that. Certainly, everything is accredited and everything has to be licensed, but still it is determined by the number of people who are going to be able to provide jobs out there.

It would seem to me that, more and more of what you are experiencing here is partially being driven by the market. Certainly, nothing that Congress did drove you to do what you did there. It would seem to me that, we seem to do more at the congressional level to make it easier for the market forces to determine which residencies, how many ophthalmologists, specialties or subspecialties or family practice people we are going to have out there. Instead of putting barriers up, we should make it easier for the mar-

ket to determine that. Instead of us just doing it, let that happen out there.

Dr. MARLON. I absolutely agree. You have heard testimony today, multiple times, about the fact that the marketplace, in terms of the jobs available are, in fact, determining what residencies are sought after, what residences are, in fact, being filled. There is no question that we will continue.

Mr. ENSIGN. The followup to that is, if we had a voucher-type system that we have talked about today, how would the logistics of—instead of having a consortium you just have a voucher and it goes to the resident and the resident determines where they go. Is that implementable in a situation like yours?

Dr. MARLON. We would be able to accommodate it, but I have to caution you about a simple voucher system, because there has to be an organizational framework, whether it is a consortium, whether it is a medical school, whether it is a hospital. I do not know enough about that and I would defer to Dr. Cutler.

It should be a variety of different opportunities. It should not only be hospitals. It should be consortiums. It should be medical schools. It should be whatever seems to get the job done within the framework of either the support being generated or people being able to, in fact, measure up to certain standards.

Mr. ENSIGN. I do not know, Mr. Chairman. From the different testimony, I have not really heard anybody come up with how this thing is going to work. Who is going to determine what specialties? Whether that is a consortium, I still do not see how that is going to work.

Dr. CUTLER. You are correct. The marketplace should drive. I would suspect that the Department of Medicine at the University of Nevada has residents at other places other than Sierra. So, the value of the consortium would be to get all the players in the room and say, what is the total number of residents the marketplace needs, could support, should be trained. What are the best venues?

It may, in fact, turn out that the marketplace can absorb 50 residents, 18 of which would be at Sierra and there might be another organization that would get zero. Bringing them together in a consortium provides the organizational framework upon which you can then ask those questions.

Mr. ENSIGN. The problem that I have—and I do not know, Mr. Chairman, what your feelings are on this. The problem that I have with a consortium-type thing is that becomes a bureaucracy in itself and the difficulty in a consortium is keeping up with those market forces. When you get in a bureaucratic environment, you end up protecting certain of your favorite—maybe you happen to like this particular subspecialty over there and that is the one your constituency—that you end up determining that you are going to protect a certain number of those.

It seems to me that, whether it is the Federal Government determining it or a private consortium or whoever it is, it is still a bureaucracy set up that stops market forces from happening.

Thank you, Mr. Chairman.

Chairman THOMAS. It is a bit of conundrum for us, because you are asking for market forces to work, but then you want to set up a structure which picks the number of folk that are going to be able

to go in there because of the market forces. You have then violated that scientific phenomenon of actually affecting what is going to occur to the market forces. So, it is like sticking a thermometer in the water to measure the temperature of the water and the water is changed by the thermometer going into it.

Notwithstanding that, we have to look at the relationship of supply and demand. I guess, the most difficult thing I have with it is, why is this area so unique that we have to create this significant limiting and screening structure based upon our reading of the market. Especially in Nevada, it seems to me, the phrase, "you pay your money and take your chances" would be the most appropriate one for dealing in this area as well.

So, you miss the number you are supposed to have. Some folk have a job, some do not. Some people decide that they are going to go into something else. Somebody goes beyond that, like a lot of the English majors, to get an M.A. so they can actually be employable.

I am just trying to understand why you use market forces and then you do not live up to the statement of market forces, because what you want is a structure that determines how many are going to go into it, based upon our reading of the market forces at that time for a job that is going to be available 8 or 10 years down the road.

Dr. CUTLER. It is a great question, but your measuring the water temperature is the answer. There is inherent, in every experiment in life a certain amount of bureaucracy or measurement costs, if you will. If you want to know the temperature of the water, you must put in the thermometer. Once you have done that you, indeed, have changed. You want to do it in a way that minimizes the costs or, the change in the water temperature, in the most 'cost-effective way.

The way you do that is, to reduce the cost, increase the margin, and increase the quality of your product. So, if you eliminate order, that is called chaos, and that is not good.

Dr. MARLON. I think the other thing is, if you want pure market forces——

Chairman THOMAS. When you say that chaos is not good and you are looking at it from an individual point of view, the whole concept of markets is the collective and not the individual.

Dr. MARLON. We are talking about the amount of money that the Federal Government spends on graduate medical education and on residency training. By definition, you have distorted the market. If you want a free market to work and I believe it possibly could, stop all payment for graduate medical education and then watch the market work. The minute you are going to throw any kind of Federal money at it, you should make some kind of rule. Now, if you do not want to make rules, stop the flow of money.

Chairman THOMAS. All right. [Laughter.]

If you do not want to take a risk, do not go to Nevada. [Laughter.]

The gentleman from Maryland wished to inquire.

Mr. CARDIN. Yes. You have made a very strong point. I am for the Federal Government providing funds, but I also believe that we must influence the outcome here a little bit. We are doing that

today. Unfortunately, the incentives that we provide, are the wrong incentives.

Market forces can work. That is an interesting concept, but it seems to me that, every trained, high-cost specialist that we produce is going to make a comfortable living in medicine today. So, we can say the market forces will work, but we know that there is no risk in going into a high-cost specialty area. There is a risk going into family practice. There is a risk going into primary care. There is a risk going into the areas that are not as well financed as far as the return to the person that goes into that area.

Yesterday, I had a chance to talk to a medical student who is going into geriatrics. She is looked upon with some degree of curiosity by her classmates. They do not know why she is interested in that field of medicine.

The stigma that we have in today's society in medical schools, among medical students and medical faculty all play a part to the distortion we have in the type of people we train in the medical field. So, I really do think we need to develop a mechanism to deal with the division of who we train in medicine and how we train. We have to deal with it. Whether it is the AMA's suggestion that we delegate this authority or whether it is some form of national standards that are developed, I do not think that the market forces will provide for the training of specialists and doctors the way they need to be without some involvement from the Federal Government.

After all, Medicare should be paying part of that cost. But, we over pay today. Instead, there should be an all-payer source of funding and most people agree to that. So, we should be able to find a way to train new graduate medical students. We also need to make sure that we have the appropriate mix of the people trained.

I appreciate that you have training programs that work. That is important. It is very important. We can try to encourage more residency or training programs in less costly settings in primary care, but if we do not do anything about the number of residency slots in this country, we are going to have a terribly inefficient health care system and we are not going to have any money to pay.

So, forces by themselves will not work. Withdrawing Federal support, to me, is not the right answer. I appreciate Dr. Marlon's suggestion there and I assume that it will be taken up by one of my colleagues soon in an amendment on the floor to withdraw all funding. Your name is going to be used as one of the reasons to support it. [Laughter.]

Mr. CARDIN. This testimony has been very useful and I really do hope that we will throw out the old models and let us take a look at some innovative approaches to encourage more residency training or more training-type programs that you have in Nevada that are wonderful. Let us have more training spots like that, but let us also encourage the brightest in our medical school classes here in the United States to use primary care as their first choice in residency. Let us have our deans of medical schools encourage more people to go into primary health care and not have a stigma from his/her classmates for the person in the class who wants to do something in primary care.

Thank you, Mr. Chairman.

Chairman THOMAS. Tell my friend that we do not have a lot of time to pursue these. We have discussed them in a number of other areas, but I do not know that the new market forces might not provide some kind of a countervailing relationship to the historical model of the high-cost specialist in the old fee-for-service world on a referral basis being able to absorb as many as they can because they could refer to each other. The new forces out there, I think, do change the equation on your ability to play the old game. It is a new game and the winners in the old game are not going to be the same winners.

So, to a certain extent, finding a job is going to take precedence over the old fee-for-service referral structure of the specialist.

Mr. CARDIN. I appreciate that, Mr. Chairman. I just wonder whether——

Chairman THOMAS. It is a slight compensation from the model that I do not think we can control. I do not know that that is not the case anymore.

Mr. CARDIN. I would be curious whether we see that in our communities. Are people who are finishing their training in residencies in high-cost specialties having a tough time finding a job? Are they making ends meet?

Dr. MARLON. They are finding that, it is a much more difficult row to hoe.

Mr. CARDIN. I appreciate that, because I have not heard that too much about people not being able to be employed with a comfortable living after finishing a residency. I take it, the cardiologists are not being hired today?

Dr. REEVES. Mr. Chairman, I can give you specific examples.

In a recent series of articles in our local paper, there were interviews with private practice physicians, the main emphasis being on how much do you estimate your pay has changed in the past 2 years as managed care has grown. The consensus was a 25 percent decrease.

Mr. CARDIN. I would like to see objective information. Doctors tend to exaggerate the circumstances that are out there. All the statistics I have seen are that, the average physician's in this country salary using current hours, adjusted for inflation, has grown.

Chairman THOMAS. I do not want to spend a lot of time on argument. I was just offering the possibility that the equation may require some rethinking.

Mr. CARDIN. If we could get some information on that——

Chairman THOMAS. An absolute requirement.

Mr. CARDIN [continuing].—that would be objective, not subjective information, but objective information.

Dr. MARLON. There is recent data to support that the number of anesthesiology residents and the number of radiology residents have gone down dramatically because jobs are not available out there to support them once they finish.

Dr. CUTLER. The residencies are not filling.

Dr. MARLON. The residencies are not filling.

Dr. CUTLER. Indeed, the shift this year to many more residents making—many more medical graduates going into primary care residencies has left a dearth of applicants for things like anesthesi-

ology, radiology, anatomic and clinical pathology. The residents in family medicine are going up.

Chairman THOMAS. Well, this might reflect then some market forces in the matching aspect of slots.

Mr. CARDIN. I appreciate the information.

Chairman THOMAS. It is just an emerging trend.

I am not dismissing the panel. The gentleman from Louisiana wanted to ask a question.

Mr. MCCRERY. I would be interested to know if any of you have a comment on our general proposal to limit the overall number of residencies. Would any of you like to comment on that?

Dr. HARR. I will take a stab at it.

Mr. MCCRERY. Sure.

Dr. HARR. If you look at the market forces and what is being required of a physician to take care of a panel of patients, and you extrapolate that into the future, the need for the current number of subspecialist physicians is definitely going to decrease, and the need for generalist physicians is going to increase. There needs to be a shift in who is taking care of the patient. In other words, the shift will be to more ambulatory-based medicine where the general internist, general pediatrician, and the family physician will be the primary physician taking care of those patients.

So, those numbers will need to increase over the current numbers. Primary care physicians constitute about one-third of the marketplace now and the reports call for half the marketplace to be physicians in those areas. Not everybody who has chosen a traditional specialty is going to want to make that transition and there are not going to be all that many jobs.

If you are an orthopedic surgeon on the west coast, you may not be able to do orthopedics on the west coast. You might find a place in Wyoming or North Dakota where you can do orthopedics or you might end up being an English teacher if you cannot find a job. The total number of physicians required in the new marketplace is different, because you have a larger number of patients that you are empaneled to take care of.

If you look at what is happening to the marketplace with the number of physicians that graduate from our medical schools and you add the 6,000 who come from afar, I do not say decrease their opportunity. Just let everybody compete. Let it be known that there are enough funded slots to accomodate 110 percent of U.S. medical graduates and you compete one on one for those slots. If a hospital or a training program wanted to have more slots and fund them on its own, let it do so. The funded slots ought to be awarded with the idea that, down the road, there ought to be x number of physicians providing care in this country.

The institutions that provide that care, if they do not follow the rules, if they do not provide the right type of physician to meet the needs of the marketplace, then they may go the way of the dinosaur and the Edsel.

Mr. MCCRERY. Dr. Cutler, do you agree?

Dr. CUTLER. Very much so. In fact, we are downsizing our residencies and most academic health centers are taking their residencies down by 5 and 10 percent a year and that matches up with the movement to ambulatory care.

Two things need to be considered. One, drop in inpatient need. But, we need more innovative kinds of ideas for training residents so we get more opportunities in the ambulatory sites. How far we take the residency numbers down and ensuring we get the right mix needs to be thought through very carefully, but that is a marketplace thought, not just a random shot in the dark.

Chairman THOMAS. The gentleman from Washington, Mr. McDermott, for one last question.

Mr. MCDERMOTT. I just want to clear up one little anomaly. When we were talking about international medical graduates, the figures that we were shown showed a very high proportion in Nevada. Explain that to me.

Dr. MARLON. Up until about 4 or 5 years ago, Nevada was an area that was underdoctored. Our ratio of physicians to 100,000 population was relatively low and up until about 5 or 6 years ago, it was a wide-open fee-for-service system. As you know that defies the laws of economics and you make as much money as you can generate in a town that grows as dramatically as Las Vegas would grow.

With the advent of managed care over the last 4 or 5 years you have seen that begin to decrease somewhat. We still have a high percentage of international medical graduates but now the number of people being licensed on an annual basis reflects the national numbers and is no longer larger in Nevada than it is any place else.

Mr. MCDERMOTT. It was something in the high seventies or 75 percent of your residencies were occupied by foreign medical graduates, is that correct?

Dr. REEVES. That is correct if you went back 3 or 4 years ago but the total number of residency spots is very low. So, one or two paces——

Mr. MCDERMOTT. Yes, I understand that.

Dr. REEVES. —from that would make a huge skew in the numbers. But you are correct.

Mr. MCDERMOTT. Is that done by recruiting? You offered them residencies, or the combination of Sierra and the medical school?

Dr. MARLON. No. That predates our involvement. Right now the residency program at the University of Nevada School of Medicine is virtually 100 percent graduates from the United States. A few years ago, these are hospital-sponsored residency programs that would not fill during the match program and would go out and fill their spots in order to fill those necessary spots, that they perceived as necessary, to provide care to indigents or Medicaid or what have you.

Mr. MCDERMOTT. Thank you very much.

Chairman THOMAS. Yes. I don't want anyone to misinterpret what I'm saying but to a certain extent with the very low population of Nevada and the location, looking for residents was kind of like the inner-city. Nevada had similar problems in terms of trying to find folks.

As the population has grown, there are a number of amenities and atmosphere which make it far more congenial to family living in the larger sense in Nevada and it will continue to change, looking more like Phoenix in terms of a population center all the time.

I want to thank you very much, if there are no more questions. Do you have one question?

Mrs. JOHNSON. I just have one question.

Chairman THOMAS. All right, one side, 5 minutes.

Mrs. JOHNSON. Yes. I just have one comment. Very briefly, a number of people who have testified have mentioned the trust fund that we have set up, in our Medicare Preservation Act, to begin funding medical education. That is the best all-payer system.

It is far better than having all-payer in terms of insurance providers and other parties, because you never get them all. All-payer is all taxpayer in our trust fund.

On the other hand, it creates allocation problems. If we get all the money into a trust fund how do we give it to you? If we are not going to give it to you per patient, if we are not going to give it to you per resident or per number of beds? In the bill, we just arbitrarily give it to you and then sort of the percentage of the Medicaid money you got last time. We can't do that indefinitely.

So, that whole issue of how do we flow the money out of the trust fund is one you have got to be thinking about.

Thanks.

Chairman THOMAS. We look forward to some ideas and perhaps some of the discussion of the consortium would help us.

The Subcommittee will stand in recess until we get back for the next panel.

[Recess.]

Mrs. JOHNSON [Presiding]. The Subcommittee will reconvene. My apologies for the delay. There were two votes and so the Members were delayed longer than expected.

For our last panel we have Mary Mundinger, dean, Columbia University School of Nursing and Lynn Caton, president of the American Academy of Physician Assistants.

Dr. Mundinger?

STATEMENT OF MARY O. MUNDINGER, RN, DrPH, DEAN, COLUMBIA UNIVERSITY SCHOOL OF NURSING, NEW YORK, NEW YORK, AND MEMBER, BOARD ON HEALTH CARE SERVICES, INSTITUTE OF MEDICINE

Dr. MUNDINGER. I am delighted to be here and pleased to have this opportunity to comment on the Medicare reform proposals to make some observations about how advanced practice nursing may pose a solution to some of these daunting problems and to make a plea for replacement funding for our Nation's inner-city hospitals and academic health centers as we go forward.

I would like to start by offering some observations about the nursing work force. There are 2.2 million nurses who are registered to practice in this country. About two-thirds of those nurses are trained at the associate degree or diploma level, preprofessional level. And another, perhaps, 600,000 nurses are trained at the baccalaureate level. A very small cohort, perhaps 100,000 at this time, are advanced practice nurses.

Chairman THOMAS. Excuse me, was that 3,000?

Dr. MUNDINGER. About 100,000 that are advanced practice nurses. The group that forms the major work force in nursing, the associate degree cohort, are really trained for hospital care and

those hospital jobs are eroding and they are changing. And as the system changes, we need nurses with far more community health experience and management experience. Those are the baccalaureate nurses.

Advanced practice nurses are those with graduate training in a clinical specialty. It is primarily in primary care that they are trained. They can diagnose and treat and manage basic illnesses. In most States they have some level of prescriptive authority and in about half the States they can have their own practices without physician supervision or collaboration.

Although there is a great deal of overlap between what advanced practice nurses can do in basic medical care, the idea is not to supplant physicians with advanced practice nurses, it is to extend the medical care that physicians give and nurses bring with that a value-added component of skills in prevention, health education, promotion, community-based care that really is a value-added piece to our traditional, very high-level medical care.

Medicare funding for nursing education is the largest single funding source. In fiscal year 1995, $245 million in Medicare funds was given to hospitals for pre-professional education. This means that the hospitals, which are training perhaps 10 percent of the nursing work force, are getting three times the federal subsidy of all other nursing schools.

We would make a plea that in redirecting those Medicare funds to advanced practice, the contribution of Medicare to the level of nursing that Medicare patients need is far more appropriate.

I would also like to observe that nurses form one of the major components of primary care in this country. If we count them in the numerator with all primary care physicians and in the denominator of specialists and primary care providers, we are much closer to the 50/50 ratio between specialists and primary care givers that is widely acknowledged as being ideal in this country.

While there is strong consensus in the Pew and IOM reports for downsizing residents, the potential damage to hospitals and patients depending on the care of IMGs, in particular, is enormous. These residents tend to practice where under-served patients are seen in inner-city public hospitals and they are much more likely to take primary care residencies.

Notwithstanding these findings, the final route of IMGs, in their career decisions, isindistinguishable from U.S. medical grads. Thirty-four percent of IMGs are currently in primary care; 34 percent of USMGs are currently in primary care. And, they are similarly distributed in geographically under-served areas.

We believe that advanced practice nurses are a potentially valuable IMG replacement. Having completed their graduate clinical training, the out-patient care competency at least is useful as a first year entering resident. They also bring with them the basic nursing skills from their undergraduate education. They have prevention, health education, and the use of community resources. They grow in competency each year and do not exit the system in 3 to 5 years establishing costly practices, but remain providing continuous high-quality care.

Let me conclude by saying that the role of academic health centers in these improvements is central. This is not only the site

of medical training, it is where medical leadership for the next generation begins. Academic health centers are not only the centers of excellence, they are the entities that make excellence in health care possible. Academic health center hospitals and clinics bear a disproportionate burden caring for vulnerable patients. It will take stable financing to secure these continuing contributions to the nation's health.

Thank you very much.

[The prepared statement follows:]

Medicare GME Financing
and
Recommendations of the
Pew Commission, IOM study, and Balanced Budget Act FY 95

statement by
Mary O. Mundinger, RN, DrPH
Dean and Centennial Professor in Health Policy
Columbia University School of Nursing
Member IOM Board on Health Care Services

Good afternoon Mr. Chairman and members of the subcommittee. I am dean of the Columbia University School of Nursing, and a member of the Institute of Medicine and its Board on Health Care Services. In 1984-85 I served as a Robert Wood Johnson Health Policy Fellow on the US Senate Committee on Labor and Human Resources.

I am pleased to have this opportunity to comment on Medicare Graduate Medical Education reform proposals, and to commend you, Mr. Chairman, for your leadership in developing the Balanced Budget Act provisions for Medicare financing improvements. The establishment of a new trust fund to support health professions education is a promising initiative, one that could secure a broader and more equitable base for health professions training.

Recommendations in the Pew Health Professions Commission Report and the IOM Report on the US Physician Supply center on the emerging physician surplus, the role IMG's play in this surplus, and the cost, financing and reorganization of the health care system. The turbulence imposed by these changes could harm academic health center hospitals where so many underserved patients receive care, and could disrupt the only access to care many vulnerable individuals now have. New York City hospitals bear a disproportionate burden of this care. The changes being considered in the health care system must protect access and quality care during this time of transition.

The site of care is shifting away from hospitals, outcomes research is informing us of better cost benefit care decisions for individuals and for populations, and under managed care, prevention and health promotion count and are paid for. These changes suggest that regulating numbers and specialty selection of physicians will be an inadequate solution to cost and access problems. New professional configurations and new cross discipline teams, including nurses, will be critically needed, and can provide solutions to these daunting problems.

NURSING EDUCATION AND THE HEALTH CARE MARKETPLACE

The US healthcare workforce currently includes over 2.2 million registered nurses. Approximately two-thirds of these RN's and two thirds of current nursing students are educated at the pre-professional level, in hospital diploma schools or two year associate degree (AD) programs in community colleges. These programs prepare nurses to provide basic nursing care to hospitalized patients, with the parameters of their practice in a structured supervised environment. Until recently two thirds of nurses worked in hospitals, but with hospital downsizing, only about 54% of nursing positions are in hospitals, and there is a rapidly growing surplus of diploma and AD nurses. To add to the disparity, the practice of hospital nurses is increasing in complexity, including care of more acutely ill and technology dependent patients, management decisions to safely deploy paraprofessional assistants, and using skills in community based care, prevention, compliance, and health education - all components of baccalaureate nursing education.

Nurses with advanced training, called Advanced Practice Nurses, (APN's), are those who have completed a graduate degree program in a nursing specialty. Most states require a certification exam, and most APN's also take a national certifying exam in their specialty. APN's include nurse practitioners who practice in primary care, clinical nurse specialists, such as a critical care specialist, who practice in hospitals with the sickest most complex patients, nurse anesthetists, and nurse midwives.

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In the past decade APN's have gained more independent authority in every state. Nurse Practitioners in 20 states have full independent authority without requirements for physician supervision or collaboration, have pharmaceutical prescribing authority in 48 states (at varying levels of drug categories), direct access to reimbursement from Medicaid in every state for some nurse practitioner specialties, and direct access to private insurance reimbursement when clients request this of their insurer. Nurse Practitioners are statutorily excluded from direct Medicare reimbursement except for rural areas and managed care plans.
Evaluation of nurse practitioner quality and competence have been the focus of over 100 published studies. In all areas of these studies nurse practitioners measure up to physician primary care practice and can manage 80-90% of the patient problems that primary care physicians can manage.

Under the fee for service system for health care that focused on disease detection and management, physicians were seen as the "gold standard", and nurse practitioner's were measured by that standard. Now, with the focus of the nation's health care on a more balanced set of skills, including prevention, health education, patient compliance and empowerment, it is clear that nurse practitioners are more than a less expensive substitute for physicians.

It has long been recognized that a physician brings extra value to a medical encounter with a patient, and that the nurse practitioner provides a medical subset of care. What has been less recognized is that the nurse practitioner also brings a unique value-added component to care. Increasingly, the value of the nursing component is necessary for quality, for comprehensiveness, for health outcomes, and for cost effectiveness. Managed care requires this broader set of health, as compared with medical, interventions.

MEDICARE FUNDING FOR NURSING EDUCATION

Medicare is the largest single funding source for nursing education. In FY 1995 $245 million in Medicare GME funds were given to hospitals for preprofessional nurse training programs. These funds go to hospitals as general revenues and are not specifically earmarked for education. More than 90% of Medicare funding for hospital nursing programs goes to private non-profit hospitals. Only 28% went to Council of Teaching Hospitals, which more often provide care to underserved patients and vulnerable high risk populations, and only 9% went to hospitals in rural areas.

Although hospital diploma programs decreased by half between 1981 and 1991, and currently enroll only 10% of all nursing students, they receive three times the amount of money that is available to all advanced nurse training programs.

Title VIII funds for graduate nurse training were $60 million in FY 95, and Medicare provided only $2.2 million for advanced practice (nurse anesthesia), for a total of $62.2 million federal subsidy, less than one percent of the $6.4 billion that Medicare spent on graduate medical education. It is estimated that the GME nursing subsidy for preprofessional hospital nursing programs could reach $420 million by the year 2000. While still minuscule in comparison with the projected $10 billion GME medical subsidy for that year, this nursing subsidy would provide crucial assistance for the training of advanced practice nurses needed desperately in the new health care system.

Without adding a dollar to existing Medicare nurse training funding, redirecting these funds to advanced practice programs from hospital training programs would begin to bring balance and rationality to Medicare support of nurse education. The Physician Payment Review Commission recommended this change in 1995, as did the Association of Academic Health Centers the same year. The Pew Commission report recommends reducing the number of nursing schools by 10-20% through closure of diploma and AD programs. This recommendation, and the following one, to increase federal subsidies for nurse practitioner education, are in the public's interest and should be enacted.

It is important to recognize that nurse practitioners are part of the nation's total resource of primary care practitioners. It would be wrong to titrate the medical workforce into primary and specialist providers without including nurse practitioners in the primary care numbers. When that

is done, the proportion of all primary care providers comes closer to the 50:50 ratio of specialist:primary care that is considered ideal.

INTERNATIONAL MEDICAL GRADUATES AND VULNERABLE POPULATIONS

The IOM report and the Pew Commission report recommend bringing first year medical resident numbers closer to the number of US medical graduates each year, giving preference to US medical graduates for residencies. The Balanced Budget Act of 1995 recommended limiting the number of residents funded by Medicare. These actions taken together could reduce resident numbers by nearly one third, making significant progress toward limiting the overproduction of physicians. In addition, the IOM report recommends replacement, not transition, funding to hospitals for International medical graduate (IMG) downsizing, and recommends that education policy be disentangled from service needs. All of these recommendations make quality and financial sense.

Concerns have been raised in this subcommittee and with others within the health care policy arena about the gaps in medical care that could occur by reducing IMG's this dramatically. IMG's are more likely to be in resident positions where underserved patients are seen, such as inner city public hospitals, are more likely to take primary care residencies, and to take practice positions in underserved and rural areas.

While strong consensus exists for downsizing residencies, and the virtual elimination of IMG's, the potential damage to hospitals and patients dependent on care from IMG's is enormous. The plight of acutely ill patients bereft of medical care could irreparably harm a health care system in our inner cities and academic health centers which is already fragile and in jeopardy. Any long term solutions must be tempered with interim investment to assure that adequate resources are in place. The IMG resource is centered in a few major areas, including many academic health center hospitals, and special attention must be given to them during this transition period.

Notwithstanding these findings, the final route of IMG career decisions are indistinguishable from US medical graduates. The same percentage of IMG's as USMG's (34%) are currently in primary care. A May 1996 CRS report suggests that IMG's initially take primary care residencies because they are most available, but eventually subspecialize to the same extent that USMG's do. IMG's and USMG's are similarly represented in geographically underserved areas.

Providing culturally sensitive care is one of the Pew Commission recommendations. With Medical school applications at an all time high, reducing medical class size or closing medical schools as a first remedy for the physician surplus could be damaging. Minority applicants are often less competitive, and yet they are a preferential resource to serve our nation increasingly represented by minorities with special cultural needs. IMG's are represented by nationalities not reflective of our major minority/international population, and would therefore be less attuned to culturally sensitive care than US applicants. The best first option to limit physician surplus would be to limit IMG positions.

Medical residents give care to hospital patients with low cost to hospitals, but the real cost to the public is high. Medicare pays approximately $70,000 a year to hospitals for each resident. But the public cost does not stop there; each resident exits the system and incurs, on average, $1 million a year in health care costs. This inordinate cost to the public cannot be legitimized where there is an oversupply of physicians. The IOM report recommends resident **replacement** funding for the service value of residents, a strategy that would have secure funding, and put in place a new structure, not simply an interim one.

Even if there were no reason to change the medical resident workforce, resident practice and responsibilities are changing dramatically. More outpatient and primary care sites demand their presence, taking time away from hospital productivity. Even in the hospital, patient length of stay has decreased so drastically that the learning time for residents is compacted and takes more time away from service contributions. Managed care also increases the necessity that the resident have knowledge of community resources, and skills in health education and compliance behaviors.

The changing of the guard each July, as a new cohort of freshly minted MD's enters the resident workforce, produces a downturn in productivity, one that the new fast paced hospital under managed care cannot sustain. Therefore, a resident replacement strategy for IMG's that places a permanent skilled provider in the position, is a quality and productivity enhancer for hospitals which will still need to find resources to enter and train new US residents.

Advanced Practice Nurses could be valuable IMG replacements working collaboratively with physicians in new team configurations. APN's, having completed a graduate degree program, already have the patient care skills that are at least as sophisticated as a beginning resident. In addition, APN's have the community and patient care/education skills that are inherent to their basic nurses training. Nurses are particularly astute in regard to cultural needs, and are therefore valuable caregivers with underserved populations. This constellation of competencies fits the managed care requirements of quick and seasoned response to patient needs, safe and early hospital discharge, and fewer costs associated with the learning process of residents. In addition, these APN replacements will not exit every three to five years to establish costly and competitive practices, but will remain in the positions, increasing in competence each year, and providing continuous quality that can sustain the cyclical process of US medical resident training. States and cities that now have the preponderance of IMG's have significant numbers of APN's and APN training programs, making the workforce transition more likely.

The Pew Health Professions Commission has recommended expansion of the National Health Service Corps (NHSC) as a means of securing care now given by IMG's to patients in rural and other underserved areas. HPSA designations also focus on filling these gaps. A recent CRS report states that these rural service deficits may worsen further under managed care as large urban networks make inner city primary care more attractive.

There are some problems in the Pew Commission recommendation to expand the NHSC; only professionals with high financial burden or lack of other job opportunities need take these positions, and they do so for limited time, not making the life time career decisions to serve in those communities. Incentives should be developed for career-long commitment that will attract quality providers. NHSC funding might better be invested in preferential reimbursement programs, or other continuous career enhancement incentives for professionals practicing in shortage areas.

MEDICARE FINANCING AND THE FUTURE ROLE OF ACADEMIC HEALTH CENTERS

The Medicare reforms developed in the Balanced Budget Act of 1995 should be resubmitted and enacted. The trust fund for health professions education is particularly important and would serve three crucial functions; it would broaden the base of funding appropriately, would shield funding from the vagaries of the budget process, and would make private sector subsidies explicit. Private contributions to health professions training, hidden in the cost base of hospitals, are probably equal to or slightly larger than the Medicare subsidy. With aggressive managed care hospital payment negotiations, that private subsidy could wither. Making the contribution explicit and required could protect health care for millions of patients. The Pew Commission also recommends this change in financing. Nurse education subsidies should be explicitly included in this trust fund; Medicare now includes nursing education funds and the new system should, also. The funding, however, should be redirected from hospital training programs to university based advanced practice programs.

A second payment reform is needed to move funds to the entity incurring costs of health professionals training; now funds flow to hospitals, and these sites are rapidly moving to private practices or other primary care sites for health professions training. The Pew Commission recommends that one quarter of medical student and medical residency training take place in primary care sites. It will take a redirection of resources to carry out this important recommendation.

The role of the academic health center (AHC) in these improvements is central. This is not only

the site of medical training, it is where medical leadership for the next generation begins. AHC's are not only centers of excellence, they are the entities that make excellence in health care possible. The cascade of new knowledge to reduce the burden of disease and disability cannot happen without dedicated research patient care research including those with expensive and rare conditions.

The Pew Commission recommends more cross discipline training, more engagement of public health professionals with the clinical professions, and development of broader competencies within medicine and nursing. AHC's are where the majority of APN's are educated, and where most Schools of Public health reside. AHC'c are where these new teams will be forged and evaluated, with doctors and nurses and public health experts working together to design and establish more comprehensive, cost effective, high quality care. It will be these innovations that can sustain the excellence in American medicine that makes us the envy of the world. It will take stable financing to secure these continuing contributions to the nation's health.

Mrs. JOHNSON. Thank you very much, Dr. Mundinger, for your testimony.

Mr. Caton, welcome.

STATEMENT OF LYNN E. CATON, PA-C, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Mr. CATON. Thank you, it's very nice to be here. I appreciate this opportunity to represent the American Academy of Physician Assistants and 26,000 practicing PAs.

In addition to serving as president this last year, I am also a PA practicing family medicine in Vancouver, Washington and a volunteer faculty member for the Oregon Health Sciences University PA program. The PA profession is slightly younger than Medicare but in our 29-year history PAs are credited with providing quality care.

It is quite cost-effective care. PAs are heavily depended upon to provide physicians services to hundreds of thousands of patients annually. We were pleased when Dr. Detmer of the Institute of Medicine and Governor Lamm of the Pew Commission appeared before this Committee just a few weeks ago and discussed GME. And, they both acknowledged the value of physicians assistants and the need to ensure an adequate supply of PAs.

The PA profession has its roots in the active-duty medical corpsmen who served in Vietnam. Today, there are 78 accredited educational programs and PA must pass a rigorous certification and recertification examination, as well as complete 100 hours of continuing medical education every 2 years.

More than 85 percent of PAs have a minimum of a baccalaureate degree and of those 15 percent have either a master's or a doctorate degree. PA education is grounded in primary care, and the disciplines of family medicine and internal medicine remain the largest areas of PA practice.

Both the didactic and clinical rotation phases of PA training are focused on the physician/PA team approach to the delivery of health care which continues once the PA enters practice. Both physicians and patients respond quite favorably to this team approach, as evidenced by the increasing physician demand for, and patient acceptance of PAs.

As someone who has completed my formal education some years ago, Federal support of PA education is no longer a help or hinderance to my ability to diagnose and treat patients, be they Medicaid or Medicare, private pay or uninsured. However, as president of the Academy, addressing the educational needs of the PA profession, is of great importance. Because PAs did not exist at the time of Medicare, we are not included in graduate medical education funding. It is available to other health care providers such as physicians, nurses and other allied health professionals.

Nonetheless, PAs, today are heavily relied upon to provide physician services to both Medicare and Medicaid beneficiaries. Congress has long recognized the value of PAs to deliver health care. The Rural Health Clinics Act, for example, requires PAs or nurse practitioners to own, or staff at least 50 percent of the time, all federally-certified rural health clinics. The clinics are also eligible for Medicare reimbursement. This Act alone has resulted in greatly

improved health care access for Medicare beneficiaries in this country's rural and medically under-served communities.

In fact, more than one-third of PAs in the United States practice in communities of less than 50,000. In addition, Congress has recognized PAs as cover providers of physician services under Medicare in numerous practice settings, culminating in a recent provision for all out-patient settings that was included in the 1995 Balanced Budget Act. Unfortunately, that bill was vetoed by the President. The Academy is hopeful that comparable provisions will be incorporated into future legislation and we would like to take this opportunity to thank the chair for supporting this legislation.

Understanding the valuable role that PAs play in providing health care to patients, the Physician Payment Review Commission adopted a recommendation last year calling for inclusion of PAs in the GME funding stream currently available to nurses and allied health professionals. This funding, projected to be somewhere between $300 and $500 million by the year 2000, is limited to hospital-based training programs. The PPRC recommendation, in addition to including PAs as eligible GME providers, would also permit training of all eligible providers to occur in 4-year colleges and universities, since the majority of providers no longer train in hospitals.

And we have heard from several panel members, preceding this one, that this is becoming a very important trend. I must add here that PAs have been doing this for about 30 years and for some of that time, before managed care, we have been able to entice physicians to actually provide payment to teach our students. So, if the general trend for medical education goes away from hospitals to out-patient settings and medical students and residents are trained in these settings, it will have a major impact on PA training.

We believe the PPRC recommendation is a good one. We urge your consideration of it for several reasons. First, it is simple fairness. Both the Medicare and Medicaid Programs are heavily dependent upon PAs to provide medical care to beneficiaries, but PAs are the only primary care providers not currently eligible for GME. Perhaps most importantly, supporting PAs with GME funding is a sound investment in an important public policy objective. GME is intended to ensure an adequate supply of providers for Medicare beneficiaries. The number of PAs in clinical practice is quite high—85 percent full time and when we add in part-time practice it jumps to 93 percent. Obviously PAs are committed to practicing clinical medicine, making them a sound GME investment.

Also the Federal Government is a significant employer of PAs. Many Federal agencies, ranging from the Department of Federal Affairs, Justice, Defense, National Institutes of Health, Indian and Public Health Service rely on PAs to provide care to their respective patient population.

The other professions heavily relied upon by the Federal Government for delivery of health care, such as physicians and nurses, have long been in the GME funding stream.

Also, despite the impressive job that States and private educational institutions and students have done in supporting the PA programs, demand for PAs continues to exceed the supply. Current PA graduates continue to report six to seven jobs per graduate. The

only funding currently available to PA programs comes under title VII of the Public Health Service's Act and is targeted for programs that graduate students who enter practice in medically underserved areas or from disadvantaged backgrounds. Title VII plays an important role but its goals are very limited in what they can achieve.

Finally, we believe that the current structure of PA programs and their funding streams would be a good model for other health professions receiving GME. Given the existing State, local and private funding of PA programs the potential for PA programs to become dependent solely on GME funds is both low and preventable. But, GME funding would go a long way toward ensuring an adequate supply of PAs. Given the Federal Government's reliance on PAs to provide needed medical services to a diverse patient population, it seems only reasonable that PAs be eligible to receive GME funding.

In conclusion, we believe that including PAs in the GME funding stream currently available to nurses and allied health professionals would not only help to ensure an adequate supply of PAs, but also to send a message to the Medicare Program that Congress recognizes the valuable role that PAs play in ensuring access to quality, cost-effective medical care.

Thank you for your attention.

[The prepared statement follows:]

STATEMENT OF
LYNN E. CATON
AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Overview

Physician Assistants (PAs) have become an integral part of the nation's health care workforce. As PAs have achieved legislative and regulatory recognition as well as professional acceptance, they have greatly improved access to primary care services throughout the United States. Unlike many health care professions, PAs have never received educational funding through Medicare graduate medical education (GME), because the PA profession did not exist at the time Medicare and GME were created.

As Medicare celebrates its thirtieth anniversary, however, PAs are depended upon heavily to provide the very services the framers of Medicare sought to make available to this country's senior citizens. The Academy believes the clinical, scientific and academic evidence strongly indicates that the time has come to ensure that PAs are among the GME-eligible provider pool. As Congress addresses proposed changes to GME, we urge you to adopt the PPRC's recommendation that PAs be included in the GME funding stream.

As reported in the *Ninth Report to Congress, Health Personnel in the United States 1993*, a higher percentage of PAs practice in rural and medically underserved areas than any other primary care providers. PAs also provide health care services where there is a lack of general physicians, such as inner city and urban underserved areas, and are also in increasing demand in managed care and HMO settings. And of great significance to the GME debate is that PAs are well suited to deliver the care now provided by residents, particularly International Medical Graduates, which seems likely to be lost in the restructuring of residency program funding.

Including PAs in GME is also a sound investment. One of the clear public policy objectives of GME is to ensure an adequate supply of health care providers who enter clinical practice and actually deliver health care. Eighty-five percent of all PAs are in clinical practice, and when those practicing part-time are added in, the number jumps to 93 percent. Congress can be assured that funding PA education through GME will achieve the fundamental objective of an adequate provider pool.

Background

A creation of organized medicine, the first PAs began practicing in 1967. In the ensuing 29 years, the PA profession has grown steadily and solidly. The profession now consists of 25,700 clinically practicing PAs, educated in accredited PA programs and certified by the National Commission on Certification of Physician Assistants. In order to maintain their certified status, PAs are required to sit for a recertification exam every six years and complete 100 hours of continuing medical education every two years. According to the AAPA 1995 census data, 85.9 percent of PAs hold a minimum of a bachelor's degree, and of that, 15.5 percent hold either a masters or doctorate. PA education is grounded in primary care, and family/general practice remains the most common area of PA practice, followed by general internal medicine.

The US Department of Labor projects a 36 percent increase in the number of PA positions by the year 2005, and self-reported data from new PA graduates indicates approximately six job offers per graduate. The demand for PAs continues to grow in part because of satisfaction by the physicians who supervise PAs. Because physicians and PAs usually train in the same medical schools, receiving instruction from the same faculty and working as teams during clinical rotations, physicians have become increasingly supportive of the physician-PA team. The team approach to health care delivery is strongly rooted in PA education, and every PA in the United States practices with the supervision of a licensed doctor of medicine or osteopathy. Another significant aspect of PA demand is patient satisfaction. A recent survey of patients who receive care from a PA found that "nearly nine in ten of those surveyed said they're very or somewhat satisfied with the care they receive. That's nearly as great a vote of confidence as the 97 percent

of patients who said they're satisfied with the doctor's medical know-how." (*Medical Economics, August 21, 1995*)

Graduate Medical Education - Eligible Providers

As noted earlier, of all the providers that the federal government recognizes as vital to the delivery of primary care services, PAs are the only professionals not currently eligible to receive GME funding. The single largest component of GME is dedicated to physician residencies. However, significant funding, equivalent to approximately 15 percent of current expenditures on Direct Medical Education for physician residents, was also established for a wide range of other health professions. While some of these professions may require graduate study today, most do not, and few, if any, did at the time Medicare was enacted.

According to the Congressional Budget Office, GME funding for the training of medical residents is expected to exceed $6 billion for FY 95; payments are projected to grow to more than $7.5 billion in the year 2000. (*CBO Report, Medicare and Graduate Medical Education, September 1995*) In addition to entitlement funding available to physicians under GME, categorical grant funding is also available to primary care physicians (family physicians, general pediatrics and internal medicine) through Title VII of the Public Health Service Act. The FY 95 appropriation under Title VII for the education of these physicians was approximately $64 million.

In addition, "Medicare is the single largest federal source of support for nursing schools," according to Physician Payment Review Commission member Linda Aiken, PhD. Aiken further notes, "Medicare funding for nursing education has been a stable and reliable resource, increasing from year to year because it is an entitlement, and thus not subjected to the congressional appropriations process. According to recent unpublished projections from HCFA, hospitals will receive approximately $248 million in Medicare support for nursing education in 1994, rising to some $420 million by the year 2000." In addition to entitlement funding available to nursing under GME, Aiken notes that "Title VIII Public Health Service monies, which constitute most of the other federal support for nursing education, now total roughly $60 million a year." (*JAMA, May 17, 1995, Vol. 273, No. 19*)

Also, 13 other health care provider training programs are eligible for GME funding under the collective title of "paramedical or allied health" personnel. PAs are not included in that definition, which covers medical technology, medical records, x-ray technology, physical therapy, occupational therapy, pharmacy residencies, inhalation therapy, hospital administration, dietetic internships, and cytotechnology, as well as professional nursing, practical nursing, and nurse anesthesia. Despite the legislative mandate for funding professional nursing, Aiken argues that, "Medicare supports primarily *pre*professional education in nursing. Graduate education does not generally qualify for reimbursement." Aiken notes that diploma nursing programs, particularly those in Ohio, Pennsylvania, and New Jersey, account for one-half of the total Medicare payments, and that "65% of all new nurses in the United States are trained at less than the baccalaureate level." Thus, the argument appears to be that professional level education is commensurate with attainment of at least a baccalaureate degree. Aiken thus concludes that "graduate level clinical education and baccalaureate education would be targets consistent with the assessed needs of the nurse workforce of the future. One example cited for reaching these targets would be increased GME reimbursement for nurse practitioner programs, not all of which qualify for Medicare reimbursement now." (*JAMA, May 17, 1995, Vol. 273, No. 19*)

PAs would be a unique addition to the GME funding stream, in that the profession has worked diligently to meet the demand for PA graduates without the benefit of GME support. There is already significant financial support from states, localities, educational institutions and students for PA programs. Yet despite the reliance on PAs to provide medical care to Medicare beneficiaries, PA programs have never been eligible for GME funding. While there is no likelihood of PA programs becoming dependent upon GME, the Academy believes it is only fair for Medicare to help support the training and education of PAs.

PPRC Recommendations Regarding GME

Commissioner Aiken made a recommendation to the PPRC on April 27, 1995, calling for a change in current GME funding away from diploma nursing programs and towards baccalaureate and graduate advanced practice nursing programs. Members of the PPRC pointed out that the initial recommendation excluded physician assistants, and directed Commissioner Aiken to work with other members of the Commission to revise her recommendation to include PAs.

The intent of the Commissioners to include PAs in their final recommendation results from much discussion and study by the PPRC about the important role that nonphysician providers, defined by the PPRC to be advanced practice nurses and PAs, play in the delivery of health care. (*PPRC Annual Report to Congress, 1994, citing a RAND study commissioned by the PPRC*) One of the key components of the PPRC's recommendation regarding GME eligibility standards for PAs and advanced practice nurses pertained to education and training programs operated by four-year colleges and universities, as well as those programs based in hospitals.

The PA profession sincerely appreciates the PPRC's recommendation and support for including PAs in the GME funding stream, as well as its recognition of the role PAs play in health care delivery. As mentioned earlier, unlike physicians and nurses, PAs historically have had no educational entitlement funding. Categorical grant funding available under Title VII for physician, dentistry and PA programs is the only federal support available to PAs, but as the PPRC has noted, "Many of these programs lost substantial funding during the early 1980s and have not yet been restored to their previous funding levels." (*JAMA, September 1, 1993, Vol. 270, No. 9*) The peak allocation for PA program funding came in FY 94, at $6.5 million. After reacissions in FY 95, funding fell to approximately $6 million. By contrast, Title VIII funding available to advanced practice nursing is significantly higher. In FY 95, advanced nurse education received a $12,253,000 appropriation, along with an additional $16,943,000 for nurse practitioners/nurse midwives. Despite similar ratios in funding levels over the years between Title VII and Title VIII, the number of clinically practicing PAs and NPs were quite similar at the time those appropriations were authorized; specifically 23,000 PAs, and 24,100 NPs. (*PPRC Annual Report to Congress - 1994; Moses, Division of Nursing, Bureau of Health Professions; Aiken, study for the Department of Health and Human Services*)

The need to expand the pool of nonphysician providers (NPPs) comes from many different sources. First, "NPPs treat many patients who have traditionally faced barriers in obtaining health care." (*PPRC Annual Report to Congress, 1994*) Second, PAs are a viable alternative to replace the services of International Medical Graduate (IMG) residents that will likely be lost as a result of GME funding reductions. And third, unlike countries with higher ratios of generalist to specialist physicians, the United States is the one country that makes extensive use of PAs, and has in fact come to rely on PAs as important and integral providers of primary care. A brief discussion of these points follows.

Medically Underserved Populations

Time has proven that with reasonable supervision requirements and prescriptive authority, PAs are able to extend physician services to patients who are underserved or who have traditionally gone unserved altogether. This is evidenced by the number of PAs who have chosen to practice in rural areas. PAs have an extremely good record of practicing in our small towns and rural communities that are traditionally underserved. As of July 1995, 34 percent of PAs practice in communities of 50,000 or less. (*AAPA 1995 Census Data*)

IMG replacements

Many experts have recommended a reduction in the number of GME-funded physician residencies. A serious concern has been raised about who will deliver the services now provided by those residents. Upon researching this question, staff of the PPRC concluded that PAs are viable substitute providers for lost residents:

> "Teaching institutions could respond to the loss of residents by . . . using highly skilled nonphysician practitioners [such as PAs]. There is growing literature documenting the

> favorable experience teaching hospitals have had using nonphysician practitioners on the wards, in critical care, and in surgery. NPPs may actually be preferable to residents. Some faculty would rather work with NPPs; they have a lower turnover rate, greater familiarity with departmental procedures, and more clinical experience than junior residents."

Further, in response to concerns that NPPs are more expensive to hire than residents, PPRC staff also noted that "NPPs may cost institutions less than salary figures suggest if they are more efficient than residents or require less faculty supervision." *(JAMA, September 1, 1993, Vol. 270, No. 9)*

Of equal importance to the question of PA substitutability is that inpatient services provided by PAs are already covered under Medicare at 75 percent of the physician fee schedule. Although hospitals may not now commonly make use of the ability to bill for physician services provided by PAs under Part B, that is likely to change if PAs were employed in larger numbers, thus minimizing the per resident loss of both Direct and Indirect Medical Education payments for teaching hospitals.

Generalist versus Specialist ratio

As the health professional workforce debate has evolved over the past few years, there has been much discussion as to the appropriate and necessary physician generalist to specialist ratio. Some have argued for a 50-50 ratio, without necessarily agreeing on how to reach that goal. Others dispute the need for such a large percentage of primary care physicians, particularly given the availability of PAs in this country, which countries with higher percentages of generalist physicians do not have.

Michael Whitcomb, senior vice president for medical education at the Association of American Medical Colleges, argues that the current supply of generalist physicians in the United States is adequate, due in no small part to the reliance on PAs to delivery needed primary care. In a cross-national comparison of generalist physician workforce data, Whitcomb notes that, "Differences between the relative sizes of the US generalist physician workforce and that of Germany and Canada are partially due to the more extensive use in the United States of physician assistants (particularly in managed care organizations)." *(JAMA, September 6, 1995, Vol. 274, No. 9)*

As Dr. Whitcomb correctly points out, PAs have evolved as a critical component of the nation's primary care workforce. And practically speaking, PAs, the vast majority of whom come to PA training with extensive science and health care backgrounds, can be trained more quickly and less expensively than physicians. The cost of educating a PA is about one-fourth that of educating a physician, and the time needed for PA training is approximately two-thirds that of medical school. The categorical grant funding under Title VII also shows that federal support of PA training is highly cost effective. In 1995, approximately half of the country's 64 accredited PA programs received an average federal grant of $135,000. With a combined first and second year class size of approximately 70 students, the per pupil support equals $1,928. By any standard that is a sound investment, and a small fraction of the estimated $58,000 to $102,000 annual cost for physician resident stipends. *(CBO Report, September 1995)*

In response to this point, as well as the question of appropriate levels of GME funding for physician residents, Kenneth Shine, MD, of the Institute of Medicine of the National Academy of Sciences, notes that "the nation subsidizes the education of a high-cost physician rather than increasing the number of physician assistants who are supported and are more likely to be in great demand in the future." *(JAMA, April 5, 1995, Vol. 273, No. 13)*

Conclusions

If we have learned anything from the health care reform debate which recently raged with such fervor, it is how quickly the pendulum can swing and how significantly the terms of the debate can change. Two years ago we faced the question of how to expand health care access to all Americans, as well as how to ensure an adequate supply of providers. The challenge before the

Congress now is significantly altered. Specifically, it is how to ensure continued access, in the most cost effective way, including the increased use of PAs as providers of primary care.

The AAPA believes it makes eminent sense to rely on well-trained PAs to provide needed primary care services. PAs, based on their shared training with physicians, are fully cognizant of the additional knowledge, skill and experience that physicians have. Physicians created the PA profession, thus ensuring that the physicians' patients would receive needed primary care services, while allowing the physician to provide those services he or she trained for additional years to learn. The physician-PA team approach to the delivery of medical care is a reflection of health care market forces in action.

It is the position of the Academy that the best course Congress can take towards ensuring an adequate supply of primary care providers, which clearly includes PAs, is to ensure that GME funding is available to PAs.

Mrs. JOHNSON. Thank you very much.

Do either of your training programs for either advanced practice nurses or PAs involve a residency type rotation?

Dr. MUNDINGER. Yes. In advanced practice nursing most of those programs are 2 years and usually the last semester is in a very concentrated clinical residency.

Mr. CATON. PAs, half their training is in a clinical clerkship. We do have some post-PA program residencies in specialty areas but the first phase of the PA education is didactic, and the second phase is residency or clinical clerkships.

Mrs. JOHNSON. Is there anywhere in the country where your organizations are participating in any consortium type training model?

Mr. CATON. In a large number of areas, especially from where I'm from, Vancouver, Washington, we participate in the WAMI program. As one of the panelists noted earlier, we have a satellite training program in Nevada that participates in the Sierra program and those students came through the Medex Northwest program.

Dr. MUNDINGER. Nursing is not, that I know of, participating in any of these consortiums. It would be so appropriate, because this is not simply a cheaper substitute for medical care, it's a real value-added component that under managed care is very needed.

Mrs. JOHNSON. One of the things that was interesting was the team from Nevada's testimony about coordinated practice and team medicine. As one representing an old manufacturing district, I have seen the incredible difference that team manufacturing makes to both quality and productivity. While I know that is a completely different area, I can really testify to the fact that the level of integrated service delivery and the level of communication and the ideas and what comes out of that is so much bigger than what the individual changes in input that it is hard to imagine.

And, I do think that one of the reasons why we have to pursue consortium training models is because they are the setting within which some of the new developments are going to take place. They are the only way we are going to develop an understanding of how to hold managed care systems accountable for quality and how to assure that they actually do all the testing and all the diagnosis that's necessary in that delicate balance through which you define what is appropriate care. It is going to be hard to reach and yet, if we don't reach it, managed care will fail. If managed care fails, we miss an enormous opportunity to, frankly, improve the quality of health care and access to health care for just really one-third or half of the population.

So, it is very important that we think bigger and broader and more creatively than we have been thinking in the past. That is part of the reason I support you so much in the things you are trying to do.

Thank you for being here.

Dr. MUNDINGER. Thank you.

Mr. CATON. Thank you.

Mrs. JOHNSON. The hearing is adjourned.

[Whereupon, at 3:59 p.m., the Subcommittee was adjourned.]

[Submissions for the record follow:]

AMERICAN ACADEMY OF NURSE PRACTITIONERS
AMERICAN ASSOCIATION OF COLLEGES OF NURSING
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
AMERICAN COLLEGE OF NURSE PRACTITIONERS
and
NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH

The American Academy of Nurse Practitioners (AANP) representing over 17,000 nurse practitioners nationally and encompassing all nurse practitioner specialties, the American Association of Colleges of Nursing (AACN), representing 480 baccalaureate and graduate nursing education institutions, the American Association of Nurse Anesthetists (AANA) representing 27,000 nurse anesthetists, the American College of Nurse Practitioners representing five national nurse practitioner organizations, fifteen state nurse organizations, and 1400 individual nurse practitioner members, and the National Association of Nurse Practitioners in Reproductive Health (NANPRH) representing 1500 nurse practitioners in reproductive health urge that Medicare funds now focused on entry level nursing education be redirected for clinical training of graduate nurses. This innovation would provide an on-going revenue source, not subject to the uncertainties of the annual appropriations process, to expand the production of advanced practice nurses, a vital resource for meeting future Medicare population needs.

The Committee's concern about physician workforce and the supply of residents, especially international medical graduates, is understandable in view of the extent of Medicare financial support and the types of physicians it produces. But the Committee should not overlook the relevance of other health care professionals such as advanced practice nurses, in meeting the needs of the health care system for workforce. As the Committee examines Medicare funding and services for the nation's elderly, Medicare's lesser-known side--the system's financial support of training for nurses, physicians, and other professionals--itself is in dire need of reform. For example, Medicare supports the costs of training resident physicians with direct and indirect Graduate Medical Education funds amounting to over $5 billion per year. At an estimated $250 million in 1994, Medicare is the largest single source of federal support to train America's largest health care profession--registered nurses. Yet, 70 percent of every Medicare dollar for nursing education goes to hospitals that operate diploma programs that produce less than 10 percent of the nation's RNs. These programs are geared toward the hospital in-patient population. Hospital downsizing, resulting in sicker patients discharged to home, means that the care once provided in a hospital setting with a myriad of sophisticated support systems must now be provided by more appropriately trained nurses working in home and community settings. By the year 2000, Medicare payments to hospitals for nursing education are projected to reach $420 million. In addition, hospitals receiving these payments are concentrated in Pennsylvania, New Jersey, and Ohio, and receive nearly half of the Medicare nursing education funds.

At the same time, growing specialization among physicians, the health system's increasing demand for front-line primary care, and the accelerating drive toward managed care, prevention, and cost-efficiency are spurring the nation's need for nurse practitioners, certified nurse-midwives, certified nurse anesthetists, and clinical nurse specialists with advanced practice skills. While there has been much discussion in the media and in Congress on how Medicare redesign may ultimately affect funding for physician residencies in the nation's teaching hospitals, nursing and other health care leaders are focusing on a concern equally as big--the need to produce sufficient supplies of advanced practice nurses for an increasingly outpatient world where more needs of current and future Medicare patients will lie. Reforming Medicare will require more effective targeting of Medicare dollars that support the training of health professionals who provide that care. Since its creation in 1965, Medicare has reimbursed hospitals for a portion of their clinical, classroom and other costs to train nurses, physicians and other health personnel with the aim of providing high-quality inpatient care for Medicare recipients. With recent and dramatic shifts in where and how health care is delivered, the time is long overdue to overhaul the other side of Medicare--its health professions education expenditures that increasingly have become irrelevant and misdirected.

At no additional cost to Medicare, money presently spent to educate diploma nurses with skills limited to basic hospital service could be used to educate Advanced Practice Nurses (APNs). APNs are expert clinicians trained to deliver primary care, manage chronic medical conditions, and address other needs of the Medicare population. They include nurse practitioners, nurse

midwives, nurse anesthetists, or clinical nurse specialists. APNs are educated in graduate nurse education (GNE) programs accredited by nationally and regionally recognized accrediting bodies.

Redirecting Medicare funds to the education of advanced registered nurses not only makes clear sense for a health system dominated increasingly by the competing concerns of quality and cost, but would support preparation of the nurses in greatest demand by today's Medicare patients. In 1965 at Medicare's inception, most categories of advanced practice nursing had not yet emerged. In the years since, Medicare policy has not kept pace with the growing prevalence and documented quality and cost-effectiveness of APNs. Annually, millions of Medicare dollars that could support the preparation of the APN instead have funded the continued production of diploma graduates, fueling an imbalance in the nation's nursing pool.

Reports from other national organizations forecast greater demand for the APN than ever before. In a 1994 report, the Pew Health Professions Commission urged doubling the number of nurse practitioner graduates by the year 2000 to offset the shortages of primary care physicians in major metropolitan centers, rural sites, and inner cities. Among their roles, the nation's approximately 35,000 nurse practitioners (NPs) conduct physical exams, diagnose and treat common acute illnesses and injuries, provide immunizations, manage high blood pressure, diabetes and other chronic problems; order and interpret lab tests; and counsel patients on adopting healthy lifestyles. Many NPs work in gerontological, pediatric, family health, women's health, and other specialties and some have independent practices. In 48 states, nurse practitioners can prescribe medications, while several states have given NPs authority to practice independently without physician supervision or collaboration.

More importantly, the NPs often provide services of the type most needed by Medicare patients: primary care at easily accessible, community based sites. These services are available at lower cost than would be possible in a hospital setting.

In a recently released report by the Institute of Medicine (IOM) on nurse staffing in hospitals and nursing homes, an IOM panel urged that increasing numbers of registered nurses with advanced practice skills be utilized in outpatient and inpatient settings to meet the demand for RNs with management, leadership, and supervisory abilities. As the panel noted, advanced registered nurses such as clinical nurse specialists not only provide high-quality and cost-effective care, especially for patients with complicated or serious clinical conditions such as Medicare patients, but are well-skilled for the sophisticated levels of practice required in today's hospitals. They work on multi-disciplinary teams and deliver a continuum of care across settings rather than focus on a "single event" of hospitalization. IOM also recommended that nursing home care be enhanced through increased presence of gerontological nurse specialists and nurse practitioners. While Medicare's role in nursing homes is limited, the patient population in these facilities is primarily Medicare eligible.

Similarly, in a recent study commissioned by the Association of Academic Health Centers entitled *The U.S. Health Workforce: Power, Politics, and Policy*, author Jerry Cromwell came to the strong conclusion that nurse anesthetists "will be in greater demand over the next ten years, and in significantly greater demand depending on how fast and how hard the public and private payors push." It is clear that the current educational system is simply not capable of producing an adequate supply for future Medicare beneficiaries.

The efforts of nursing organizations in the 104th Congress have been to focus on redirecting Medicare funding for hospitals operating diploma programs into APN education. The following Medicare changes would provide a greater benefit to the Medicare population.

1. Redirecting eligibility to add "jointly operated" programs and to phase out diploma programs.

Since the inception of Medicare, nursing education has shifted almost entirely to community colleges, senior colleges, and universities. At present, Medicare reimbursement for nursing education programs is limited by the "provider-operated rule," which directs most of the funding to hospitals that operate diploma programs that produce entry level nurses who are trained in hospital oriented care. Most APNs represent categories of providers not in existence when Medicare educational payment policies were designed, such as nurse practitioners, clinical

specialists, and others. Educational costs of these new providers are, with one exception (nurse anesthetists), not eligible for Medicare reimbursement now. Consequently, reimbursement eligibility requirements should be changed to include "jointly-operated" (provider-academic) programs that incur costs for APN education. To be eligible for reimbursement, Medicare providers would have to: 1) demonstrate that they incur clinical costs for the support of graduate nurse education programs, and 2) have a written contractual agreement with the program's academic partner institution. Cost items for determination of Medicare's share of reimbursement could include student stipends, costs of nursing clinical faculty, and supervision of APN students at the clinical site. (Now the students, school, and clinical sites bear these costs.) Determination of the specific cost of education would be based on a modest stipend, an appropriate ratio of training faculty to students, and faculty and supervisory salaries.

A major limitation in educating APNs, is the need for resources to cover costs of clinical faculty. Redirection would allow for additional clinical faculty to expand the number of APNs in training, thus helping to eliminate the waiting lists that many graduate nursing programs are experiencing. Indeed, Medicare reimbursement would give practice sites an incentive to take on additional students for clinical training, particularly because the numbers of specialty physician residencies likely are to be reduced. The lifting of restrictions on Medicare funding for nursing education would result in increasing the production of APNs, (both in terms of number and their program completion time) making cost-effective care more readily available to the Medicare population.

Unlike medical residency programs, most nursing programs pay their own clinical training faculty or make arrangements with preceptors at clinical sites to provide clinical training at patient care sites outside the schools' academic facilities. The cost of faculty at the clinical site and cost of preceptorships for advanced nursing students, however, are actually part of the cost of providing patient care because patients, including Medicare beneficiaries, receive the benefit of the care delivered by graduate students and their faculty. In almost all cases, APN students are RNs licensed to practice in a variety of patient settings, and most have practice experience as well.

2. Clarifying "provider" definition to include outpatient facilities serving Medicare patients.

Medicare defines "provider" as "hospitals, skilled nursing facilities, home health agencies, and other facilities." With health care delivery for Medicare populations evolving beyond the hospital to more accessible and lower cost, community based sites, ambulatory care facilities, as well as tertiary care sites, should be reimbursed for costs incurred for clinical training of APNs. Support for training in these settings where primary care is delivered is critical. The Medicare definition of "other facilities" should be clarified to include those facilities that provide health care to Medicare recipients, with or without links to acute care settings, including, but not limited to, nurse managed centers, ambulatory care facilities, community health clinics, health maintenance organizations, and public health departments. Reimbursing clinical sites for training APN students recognize the value of their services to Medicare patient care. As the number of specialty resident physicians is reduced, APNs could deliver many services formerly performed by resident physicians, as well as nursing care, and maintain quality of care. Acute care nurse practitioners are already working in a number of clinical sites.

Under this proposal, facilities that incur clinical costs for support of APN education would have access to Medicare funds, but only for the portion of the cost attributable to the Medicare patient population. Thus, for a site with 30% Medicare patients, about 30% of the training costs would be eligible for reimbursement. (This is the same formula used now.) Medicare funding would provide resources for added clinical faculty to expand the numbers of APNs in training, and promote quality service to the Medicare beneficiary. With an increasing proportion of older Americans, APNs are precisely the type of health professional the Medicare population will need for its primary care, management of chronic medical conditions affecting older people, and patient education to help this population avoid injury and expensive hospitalization of nursing home care.

The APN is a vital component in increasing access to quality health care services for Medicare patients in a rapidly changing health care environment. This is the time to shift Medicare funding toward the recognized need for advanced practice nurses. Other organizations support the redirection of Medicare dollars to APN education. In April 1995 the Physician Payment Review Commission (PPRC) recommended that advanced degree nursing programs operated by four-year

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colleges and universities be eligible to receive Medicare funds that otherwise would be available only to hospital-operated programs. In July 1995 the Association of Academic Health Centers (AAHC) supported the allocation of funds for graduate nurse education by directing Medicare funds towards APN programs. Supporting APN education with Medicare dollars also has been urged by the Tri-Council for Nursing which, together with AACN, includes the American Nurses Association, American Organization of Nurse Executives, and National League for Nursing.

Redirection of the current Medicare monies for nursing education to APN education will increase the numbers of APNs and will ensure that Medicare patients will have the benefit of their skills in the future. Since the vast majority of undergraduate nursing education programs do not currently benefit from Medicare funds, the national supply of these personnel will not be adversely affected by the redirection of Medicare nursing educational dollars into advanced practice training. The redirection of these funds to APN education requires no new Medicare expenditures and could actually reduce expenditures. By recognizing only clinical costs of APN education and limiting eligibility to full-time APN students, costs would decrease substantially. Funding levels should not be reduced for those APN programs that currently benefit from Medicare support, such as nurse anesthetist programs. Redirection of funds would focus Medicare support on the preparation of the nurse in great demand by the Medicare beneficiary population, and help meet the needs of a health care delivery system that is changing for Medicare and other patients.

As the Committee considers Medicare reform and health care workforce issues, nursing groups ask that it examine the current structure of Medicare funding for nursing education and graduate medical education and the on-going changes in health care delivery. We urge your support for APN education at a time when these nurses are in great demand and capable of meeting the sophisticated needs of today's Medicare beneficiary.

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the U.S. House of Representatives
on
Financing Graduate Medical Education

June 11, 1996

The American Hospital Association welcomes this opportunity to testify on Medicare payment to teaching hospitals. The Association's membership of 5,000 hospitals, health systems, networks, and other providers of care includes the full array of teaching hospitals: university-based academic medical centers, hospital-based independent academic medical centers, affiliated community teaching hospitals, VA medical centers, and military hospitals. These AHA members are the settir for the vast majority of residency programs conducted in our country.

SUMMARY

The deliberations of this subcommittee on payments to teaching hospitals are of special importance to AHA members, physicians-in-training, and the communities they serve. Medicare is the largest payer for hospital services. Its policies for medical education have an impact far beyond the monies spent. They set the social benchmark for other payers--private and public. Thus, hospitals urge the subcommittee to consider the following points as it re-examines policies for paying teaching hospitals. Medicare payment policies for teaching hospitals should:

- recognize the higher costs of teaching hospitals;
- provide clear public recognition of the social missions that teaching hospitals fulfill in our nation;
- help teaching hospitals continue their historical mission of caring for a large proportion of beneficiaries who lack personal physicians in private practice;
- provide continuing access to essential hospital care in underserved communities; and
- set important precedents for supporting medical education and uncompensated care in a payment environment moving toward capitated health care plans.

Given these multiple impacts, changes being considered by the subcommittee could either reinforce traditional commitments and demonstrate new initiatives, or potentially jeopardize both hospitals and the communities they serve. Therefore, the AHA would be pleased to work with the subcommittee as it continues its deliberations in the weeks ahead.

STATEMENT

Since its origin, Medicare has recognized and supported the additional costs teaching hospitals incur in sponsoring and conducting residency training programs for physicians. In the cost-based reimbursement era, Medicare recognized and paid its share of these costs. When Section 223 and TEFRA payment limits were adopted, Medicare recognized its share of the direct program costs of medical education and provided special exceptions and/or adjustments for the higher hospital costs accompanying medical education. Under Prospective Payment, Medicare has paid a prospectively determined amount per resident for the direct costs of graduate medical education programs (DGME payments) and an adjustment to the DRG rates based on the ratio of residents-in-training to the number of beds (IME payments). In this way, Medicare has set an important precedent for all payers, public and private. In short, Medicare's policies have been the national role model. The importance of this role model cannot be overstated.

Now, as market-based health reform occurs throughout the nation, it is vital that Medicare continue to set the social benchmark for all payers. No other payer will feel obligated to set a higher standard than Medicare. If Medicare reduces its historic commitment to support hospital costs for physicians-in-training, other payers will use the Medicare policy as justification for failing to support these costs. **The AHA strongly urges the subcommittee to continue Medicare's support for the educational costs of teaching hospitals.**

The AHA also wishes to remind the subcommittee of the relationship between the DRG update factor and IME payments to teaching hospitals. Because IME payments are calculated by multiplying the base DRG rate by a formula based on the ratio of residents to beds in a hospital, reductions in the update factor automatically decrease the payments that are made for IME. For example, if the update factor is reduced from 3 percent to 2 percent, IME payment increases will simultaneously be reduced from 3 percent to 2 percent. Thus, while Congress has retained the current formula for IME for several years, the DRG update reductions enacted by Congress have also reduced spending for IME payments. **The AHA strongly urges the subcommittee to acknowledge that IME payments are directly affected by reductions in the DRG update factor. Teaching hospitals will be impacted twice if the DRG update factor is reduced and the IME formula is reduced.**

In the past several years, there has been a number of reports and recommendations urging the federal government to limit the number of residents in training and to allocate positions by specialty to teaching hospitals. While this approach may have been consistent with the health planning legislation of the early 1970s, it is inappropriate to the market-driven changes occurring today. Hospitals are adapting to changes in their local communities. Any effort to superimpose a national resident allocation structure on local, market-based reforms will produce unintended and harmful results. Hospitals are already revising residency training programs to better match the needs of their markets. **The AHA believes there is no need to enact a system for allocating resident positions to local communities or to teaching hospitals.**

Last year, the Budget Reconciliation Conference Agreement included an important initiative to help ensure that hospitals continue to have the funds necessary to provide the residency training required before physicians can establish independent practice. Recognizing that payment systems are changing, Congress proposed new trust funds for medical education, which would be supported by Medicare payments as well as general revenues. While this approach is an important step, the use of general revenues could result in funding being affected by federal budgetary pressures rather than the needs of patients and graduate medical education programs.

A federal trust fund for graduate medical education supported by both public and private payers is essential as individual payers seek to establish the lowest prices for their enrollees. Unless such a fund is established and adequately supported, teaching hospitals will have to choose between being price-competitive by reducing their educational responsibilities, or retaining their responsibilities and being priced out of the market. **The AHA congratulates Congress for proposing graduate medical education trust funds in 1995 and encourages further refinements that emphasize the participation of private payers and self-insured entities in supporting the fund.**

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Residency programs began in the inpatient units of teaching hospitals. Over the past two decades, an increasing amount of residency training has moved to ambulatory training sites, both hospital-based and free-standing. Medicare has recognized hospital-based training, both inpatient and outpatient. It has also recognized hospital-supported programs in non-hospital sites. Nevertheless, there is a need to expand support for residencies in ambulatory training sites, home and community service sites, and long-term care sites. **The AHA believes a trust fund for graduate medical education is an appropriate vehicle for supporting a broader array of training sites that are better suited to contemporary needs of residency programs.**

As Congress continues to work on a trust fund for graduate medical education, there is an opportunity for a more limited immediate step. Medicare beneficiaries are increasingly selecting private health plans for their coverage. These plans are paid a fixed monthly payment based on the county of the beneficiary's residence. The payment, known as the Adjusted Average Per Capita Cost (AAPCC), includes both DGME and IME payments made under traditional Medicare. There is, however, no requirement that the health plan use the portion of the AAPCC that results from the DGME and IME payments to support medical education. As a result, the health plan benefits financially if it can avoid using hospitals that support medical education. **Therefore, the AHA supports removing the DGME and IME payment amounts included in the AAPCC and making those payments directly to the entities that incur the costs of graduate medical education programs.**

CONCLUSION

The Subcommittee on Health has periodically reviewed Medicare policy for supporting graduate medical education. The AHA has always welcomed these opportunities to share its views with the subcommittee and describe, whenever possible, the impact of proposed changes on hospitals, physicians in training, and local communities. We appreciate this opportunity to present a statement and we look forward to a continuing dialogue with the subcommittee.

STATEMENT OF THE AMERICAN LUNG ASSOCIATION
AND
THE AMERICAN THORACIC SOCIETY

The American Lung Association and members of its medical section, the American Thoracic Society, would like to thank the Ways and Means Health Subcommittee for the opportunity to comment on the U.S. physician workforce needs. The American Thoracic Society is a professional, scientific society of health care providers and scientists dedicated to the advancement of pulmonary medicine. As such, the American Thoracic Society has an interest in federal policies regarding professional training and physician supply.

We would also like to give special thanks to the Institute of Medicine's Committee on U.S. Physician Supply and the Pew Health Professions Commission for their work in defining the current challenges facing policy makers regarding U.S. physician workforce needs and developing a set of policy options to respond to the perceived trends. The work of both the IOM and the Pew Health Profession Commission was thorough and balanced. They should be commended for their work.

Although we are grateful for the effort of these commissions in collecting and reviewing existing data on physician supply trends, we view the work and recommendations of these committees as preliminary. Congress should exercise caution in reviewing the policy recommendations of the IOM and Pew Health Professions Commission report.

The American Lung Association and its medical section, the American Thoracic Society, have four specific comments we would like to relay to the Subcommittee:

1) Data suggesting a U.S. physician surplus will occur in all specialities should be viewed as preliminary.

2) Time should be allowed for market forces to respond to changes in physician supply.

3) Caution should be used in considering closing existing schools; intermediary steps should be used first.

4) Alternative funding sources for providers of care in under served areas should be developed and implemented before changes to foreign medical graduate residency payments are initiated.

1) Data suggesting a U.S. physician surplus will occur in all specialities should be viewed as preliminary.
Although recent studies have suggested a potential surplus of physicians in the U.S. in the future, such data should be viewed as preliminary. Recent studies, though using accepted and appropriate methodological techniques, do contain a number of major assumptions that may or may not be accurate estimations of future trends in the U.S. health care market. Should these assumptions prove to be incorrect, the projections of U.S. physician surplus could prove to be widely inaccurate.

Additionally, we are concerned that current studies make projections only on aggregate U.S. physician supply. Such studies are not sensitive enough to elucidate needed changes in the U.S. physician mix. We are particularly concerned that a quick response to perceived physician surplus may reduce the number of trainees in critical care medicine. Recent technologies and changes in U.S. demographics may require an increase in the number of subspecialty-trained critical care physicians.

2) Time should be allowed for market forces to respond to changes in physician supply.
Clearly the federal government, through the Medicare program, is a large stakeholder in supporting the cost of physician training in the U.S. While we recognize that the federal government has a compelling interest in ensuring appropriate supply of physicians in the U.S. we urge extreme caution in using payments through the Medicare program to change current physician supply trends. The American Lung Association and the American Thoracic Society strongly urge the Subcommittee to allow time to determine how market forces may lead to

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changes in the U.S. physician supply. We are concerned that major changes in the Medicare program could result in unforseen and unintended consequences.

3) Caution should be used in considering closing existing schools; intermediary steps should be used first.
The Pew Health Profession Commission recommended that U.S. medical schools be closed to reduce enrollment by 20 to 25 percent. Although reducing the number of medical school graduates may be a necessary step, should projections regarding physician supply be accurate, we would urge extreme caution in recommending closing existing schools. The mission of medical schools extends beyond providing training to health care providers. Medical schools provide care in their communities and in many cases are the only point of access to care for low income populations. Further, medical schools play an important role in the local economy and in many cases are the primary employer. Medical schools also play a prominent role in conducting basic clinical research. Closing existing schools would have severe consequences to the health and economic infrastructure of local communities and could hurt the U.S. position as the leader in biomedical research.

We would suggest to the Subcommittee that there are a number of intermediate steps to pursue before considering closing existing training facilities. We recommend considering reducing class size and distributing information on physician employment prospects to undergraduates as mechanisms to reduce enrollment. These steps and others should be exhausted before considering closing existing medical schools.

4) Alternative funding sources for providers of care in under served areas be developed and implemented before changes to foreign medical graduate residency payments are initiated.
We support the recommendation that an alternative funding mechanism to support providers of care in under served and low-income communities be developed. We further recommend that such a funding mechanism should be fully developed before reductions in residency payments be initiated. Providers of care in under served areas should be held harmless in any transition to a new payment system for medical residency training programs.

In summary, the American Lung Association and its medical section, the American Thoracic Society, commend the IOM and the Pew Health Professions for their efforts to identify trends and policy options to meet future U.S. physician supply needs. We look forward to working with the Committee as it considers policy options for the future U.S. physician workforce needs.

June 21, 1996

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RE: Statement for the June 11, 1996 House Ways and Means, Subcommittee on Health Hearing on Graduate Medical Education (GME)

Statement on Medicare reform in relation to Graduate Medical Education (GME) and Teaching Hospitals from Louisiana State University Medical Center

Funding for GME from Medicare is vitally important and crucial for Academic Health Centers and Teaching Hospitals, whose role in turn is vital and irreplaceable in health education, research, and patient services for this nation. These institutions and their contributions to the Health Care workforce, new biomedical knowledge, and patient care delivery are recognized as the best in the world. The return on this investment to Medicare patients is substantial, as well as, proportional.

We agree that funding from Medicare for GME should be reexamined and reset in proportion to necessary changes in the total Medicare funds to achieve a balanced budget. A major concern is not only the amount and source of GME funds, but also the distribution to assure that the residents and the GME programs are the proper recipients. The accredited GME programs originating the recruitment and providing the education in the context of patient services should be designated to receive such funds, thus directed to the Medical Schools or if Medical Schools are not primary the Teaching Hospitals or a consortium fund for this purpose. This should ensure proper reimbursement of medical education costs by managed care contracts, and other federal and public funding, distributed properly to the accredited entity that incurs the cost and responsibility of training.

In Louisiana, LSU Medical Center operates two primary Academic Health Science Campuses in New Orleans and Shreveport. Our GME programs involve two separately accredited Medical schools and multiple affiliated teaching hospitals. We own and operate our University Hospital in Shreveport, but do not do so in New Orleans. Currently about 1000 residents and fellows are educated in this system, predominantly in public teaching hospitals spread geographically throughout the entire state. In respect to last years proposal on GME, we have and alert you to a technical problem; LSUMC is the accredited GME program but does own or operate the teaching hospitals except in Shreveport. If the hospital or other institution receives the funds, the problem is that we may not be reimbursed the full amount even though we incur the costs. This problem should be solved by payment directed to the GME program responsible, i.e. the LSU School of Medicine, to reimburse the cost.

Thus we depend predominantly and heavily on Federal Medicare funding and on Medicaid as well as Veterans Hospital funding to provide for the cost of training the future workforce, the majority of whom stay and practice in Louisiana. A very large amount of patient care is delivered to Medicare, Medicaid, and the uninsured and indigent patients through this system.

Therefore, we express our concern, as changes take place in the public and private sectors, that the funds from Medicare for GME continue in proportion, properly directed to pay the costs of workforce training and public service. Academic Health Centers in the United States, including LSUMC, are challenged by reductions in funding upon us and potential, in all of our missions for providing excellent education, research, and patient care. Funds for

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education are being reduced by state, research grants are harder to obtain and sustain, and patient care reimbursed is less as managed care and negotiated contracts increasingly enter the market place. We cannot and should not lose our competence, capacity, or competitive edge for providing these vital and interrelated national services.

In this context, we favor the development of an all payor system from both public, Federal and State, and private entities. We favor targeting the subsidy for teaching hospitals to facilities with the highest uncompensated care costs due to uninsured patients and severity of illness factors. We favor combining the DME and at least some of the IME funds with other sources to provide for continuity and stability. We favor a transition period of 5 years to allow adjustments needed in a changing system.

In respect to anticipated changes in Medicare, legislation can and should go only so far. Some incremental and even substantiated adjustments can be written into law, with continual performance under the same federal system accomplished. However, certain proposals, if implemented, require more monitoring, careful decisions and allocations, and considerable and constant updates. There are also to be acknowledged significant trends currently underway, chosen by institutions and individuals, achieving desired outcomes. The prescription of law may be neither necessary or desirable as creeping incrementalism is working.

Some significant trends demonstrate that more American Medical School graduates are going into primary care, and these GME programs are enlarging. The overall cost of health care in the U.S. is rising more slowly. The increase in the number of total residents and the physician workforce is slowing in relation to countrywide needs.

As these trends and responses take place, proper study, reporting, discussion and policy become considerably more important - first do no harm. Thus a balance is desirable as to what should be set into legislation and what should be purposefully omitted. Innovation is desirable, likely to occur with good policy and fewer rules.

For the purpose of improved monitoring, more study and data reporting, and better decisions chronologically, we favor the creation of a new commission on GME of objective, knowing, and responsible persons. This could be accomplished under HHS.

Not withstanding the above, certain limits and incentives may well be appropriate at this time. We favor a limit set for the total number of GME positions countrywide. The minimum position is a moratorium on the current number, nationally and for states.

Incentives to institutions to encourage primary care recruitment, programmatically and individually are desirable. Full reimbursement for the first 5 years of residency programs, less for later years is one possibility. Pay back for finishing GME participants entering public service or under served geographic areas is another. We are in general agreement with the fundings of the studies by the Institute of Medicine, the PEW Commission, and the AAMC and AAHC that emphasize and concentrate efforts and resources on the opportunities for GME positions for U.S. Medical School senior graduates.

Finally, we favor the carve-out from the negotiated budget of a medical student education fund. A small percent (2%) of Medicare GME funds should be set aside to be distributed to U.S. Medical Schools. This is the pipeline to graduates and to GME, and these costs are represented in the workforce and service provided by these professional schools as part of the Academic Health Center.

For Louisiana State University Medical Center

Mervin L. Trail, M.D., Chancellor

Perry G. Rigby, M.D., Director, HCS

WRITTEN TESTIMONY

NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

The National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) is pleased to present written testimony to the committee on the issue of graduate medical education (GME). Specifically, we support reform of GME to include a transfer of current funds from diploma nursing programs in hospitals to a new fund for graduate nurse education (GNE), to include masters-level advanced practice nursing education in clinical settings.

NAPNAP represents over 5,100 pediatric nurse practitioners (PNPs) nationwide. We are a growing field of efficient, qualified primary care providers, with a special commitment to enhancing health care for infants, children and adolescents.

Nurse Practitioners Fill A Growing Need

As the committee knows, the need for primary care providers continues to exist and increase in the United States. The private and public sector shift toward managed care has increased the emphasis on primary care and placed a greater demand for and on primary care providers.

At the same time, geographic distribution of health professionals continues to create an access problem for underserved areas. The Health Resources and Services Administration reports that two-thirds of the nation's 3,000 counties have shortages of health professionals. These positions in underserved areas are traditionally hard to fill with U.S.-educated physicians.

Nurse practitioners (NPs) are uniquely qualified to help answer the demand for primary care providers. NPs serve many health care needs throughout the country, particularly in rural and underserved areas. They provide quality health care services at a level equal to or better than physicians, and are less costly to educate. NPs perform routine physical exams, immunizations, prevention education and screening, treat minor illnesses, and perform other health care services.

NP practice is broad in scope. NPs have full practice authority and are able to practice without direct physician supervision in 20 states. NPs have prescriptive authority in 48 states. Most private insurers reimburse NPs directly, as do most public programs, including CHAMPUS (health insurance for military families), FEHBP (Health insurance for Federal employees), and Medicaid for specialties like PNPs. Direct Medicare reimbursement recently passed Congress, but was included in the Medicare reform legislation that was vetoed. We hope that it will be enacted into law in the near future.

The Pew Commission, the Institute of Medicine (IOM), the Physician Payment Review Commission (PPRC) and others have recognized NPs for their role in providing efficient, quality primary care and their potential to help alleviate primary care shortages in underserved areas.

Medicare Medical Education Should Focus on What is Needed

Given the above situation, investment in the education of health care professionals like NPs is a prudent and worthwhile federal initiative. Funding nurse practitioner education programs is an investment in primary and preventive care for service in parts of the country where the need is the greatest. We believe this funding is a needed investment, with a sizable return.

Currently, although Medicare is the largest single source of Federal funding for nursing education, over 90% of its funding goes to entry-level, diploma nursing programs. Diploma nursing schools, which train registered nurses primarily for inpatient care such as that offered in hospitals, have decreased as a result of the changing demands of the marketplace. Only 10% of all registered nurses graduate from diploma programs. At the same time, the need and demand for advanced degree programs, which educate NPs in outpatient settings and prepare them for careers in primary care and service in underserved areas, are growing. Due to limited funding sources, however, these programs are struggling to pay for qualified clinical faculty and are forced to turn qualified applicants away.

Since the marketplace and changes in the health care delivery system have driven more care to outpatient settings, while shrinking the need for care in hospitals, NAPNAP believes it is time for Medicare to shift nursing education to meet the demands of outpatient and primary care needs. We recommend that Medicare redirect its funding for nursing education, without incurring additional costs, from the entry-level diploma programs to the advanced degree nursing programs. Such a shift would ensure that Medicare is preparing nurses who can efficiently provide quality care for future Medicare beneficiaries.

Conclusion

NAPNAP commends the committee for addressing the current Medicare GME program. As our health care delivery system continues to change and evolve, Medicare also needs to adapt and adjust in order to sustain high quality, efficient care for its beneficiaries. We believe that advanced degree nursing programs are well-suited to help meet the challenges of future care for Medicare beneficiaries, and we urge the committee to re-target nursing education funds as part of GME reform.

UNIVERSITY OF MARYLAND
AT BALTIMORE

OFFICE OF THE DEAN

Statement of Donald E. Wilson, M.D., M.A.C.P.
Dean, University of Maryland School of Medicine

submitted to the

House Ways and Means Subcommittee on Health

June 11, 1996

Chairman Thomas, Members of the Subcommittee: Thank you for continuing your examination of Graduate Medical Education (GME) and the Physician Workforce in the United States. Few issues are as complicated as determining efficient and equitable models for the financing of Graduate Medical Education, and supporting appropriate mechanisms for shaping the size and specialty composition of a physician workforce adequate to serve the full range of our country's health care needs.

125 accredited U.S. medical schools - and the teaching hospitals, health systems and other clinical and research organizations with which they are affiliated in academic health centers - are an essential component of the nation's health care system. They provide all levels of patient care - from preventive to quartenary services; furnish a disproportionate share of health care services to the most disadvantaged members of society; ensure the availability of highly trained health care providers, including physicians, nurses and other health professionals, by serving as principal sites for clinical education; and provide the environment and expertise for the conduct of basic and clinical research leading to the introduction of new, lifesaving drugs, treatments, devices and procedures. The increasingly rapid transformation of the American health care system to a market-driven, price-competitive structure threatens the fiscal stability of the academic enterprise and its ability to maintain commitments to research and education, as well as patient care. Yet the current method of funding GME - having the Federal government assume much of the burden for financing broad social responsibilities, and funneling its contributions through the Medicare program to inpatient hospital settings - does little to encourage a rational and equitable distribution of such costs across the health care system and actually impedes innovation in clinical training.

Graduate medical education -- the clinical training of physicians after their graduation from medical school -- is an expensive proposition. While salaries paid to residents and interns are relatively low, other costs associated with training are not. Teaching programs must recruit and support experienced faculty to teach and supervise trainees. Teaching hospitals must incur the additional indirect costs of training residents and interns such as additional diagnostic tests and therapies and the time needed by young doctors to effectively treat their patients, as they master up-to-date techniques and state-of-the-art procedures. The costs of graduate medical education are increased still further by the intensity and expense of services provided in training facilities. That is because the most severely ill and difficult to treat patients are seen in the teaching hospitals and academic medical centers which have the specialized departments and research capabilities necessary for their care. On average, the clinical education of each resident or intern training at a hospital in Maryland, for instance, costs well over $100,000 per year.

Historically, academic health centers have relied on patient care revenues to cross-subsidize the costs of graduate medical education. But today most purchasers of health care, whether managed care organizations or traditional insurers, want to pay only for those services that they judge

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necessary for the care of the patients for whom they are fiscally responsible. Where once patients could go to almost any hospital on the recommendation of their physician, today most must have their care pre-approved and are directed to "in-plan" facilities. In an environment in which cost has become a primary criterion for inclusion in managed care networks, patients can be directed to less expensive hospitals, those without graduate medical education costs. As a result, teaching physicians and hospitals are under considerable pressure to price their services to meet the lowest price in the local market. But there is a difference between the prevailing market price of health care services and the costs of care at academic health centers - the difference caused by the educational and research missions of academic medicine, as well as the provision of uncompensated care to the 41 million uninsured in this country. Obviously, these costs will not disappear simply because the competitive marketplace "refuses" to assume them. Someone has to pay for the education of the next generation of health care professionals.

In the absence of a marketplace in which all insurers or sponsors of patient care programs support a fair share of the academic mission of teaching hospitals and teaching physicians, Medicare's explicit payments for direct graduate medical education (DGME) and the indirect medical education (IME) adjustment have taken on crucial importance. But the payment mechanism - directing GME funding exclusively to hospitals - is increasingly out of step with today's clinical training, both graduate and undergraduate. Care that once was delivered in a hospital is now being provided in clinics, ambulatory surgery centers, community health centers, and other alternate sites, and medical educators have recognized that if physicians are to practice appropriately in the future, it is important for them to be trained in similar settings. Our students at the University of Maryland, for example, interact with patients in primary care and ambulatory settings throughout their four years of medical school.

The Association of American Medical Colleges (AAMC) believes that the funding for graduate medical education should support residents and programs in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the residents (and their future patients.) Further, GME payments should be made to the entity that incurs the cost of training physicians. Payments could "follow" residents to teaching hospitals, ambulatory surgical centers, medical schools, multi-specialty group practices or other organizations, formally organized under the umbrella of a graduate medical education consortia responsible for assuring continuity and coordination of training and for distributing payments across various training sites.

Discussion of GME funding invariably leads to consideration of physician workforce issues. It is widely reported that the U.S. has an excess of doctors, especially specialists. But, despite this wealth of physicians, there is no doubt that geographic, financial, social and cultural barriers leave many in this country without adequate medical care. Some argue that the GME funding system should be used to shape the workforce, producing fewer physicians overall, concentrated more in primary care areas, less in specialties. Others believe that the employment market for physicians will adequately address issues of supply and distribution. Two points are worth making briefly. While there has been an explosion in the number of international medical graduates (IMGs) who come to the U.S. for residency training, for more than a decade American medical schools have graduated essentially the same number of new physicians each year. And our students are not ignorant of the economic realities of the new marketplace; for the last two years more than half of U.S. medical school seniors - (66% of 1996 University of Maryland School of Medicine graduates) - have chosen a residency in one of the generalist disciplines.

Funneling Federal support for graduate medical education only through Medicare does not implement health policy in a sensible way, since the elderly are not the only, or even the primary, beneficiaries of the clinical training of physicians. More importantly, the present system of gentlemanly cost-shifting and implicit cross-subsidization masks genuine social responsibilities which should be borne by all. Increasingly, it encourages insurers and other payers to make purchasing decisions based not on quality but on the opportunity to avoid education and other "unnecessary" costs. Market forces are indeed shaping the physician workforce and redirecting the energies of the American health care enterprise. Today it makes little sense to rely on a federal subsidy, to exempt the market from significant costs in the system. Nationally, funding for graduate medical education should occur through an all-payer system, ensuring that all -- patients, physicians, private and public insurers, managed care companies, and society as a whole -- who benefit from the fruits of the finest medical education system in the world contribute equitably to its costs, reducing the current disproportionate reliance on Medicare as a funding source and, ultimately, diminishing the role of the Federal government in establishing and shaping medical education policy.

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Comments for the Record
by
William A. Peck, M.D.
Executive Vice Chancellor and Dean
Washington University School of Medicine
before the
Ways and Means Committee
Subcommittee on Health

June 4, 1996

Academic health centers (AHC) consist of a medical school or college of osteopathy, one or more affiliated teaching hospitals, and usually one or more other professional schools or programs. Medical school faculties, via affiliated teaching hospitals, provide care to community residents, provide undergraduate, graduate and continuing medical education, perform cutting-edge biomedical research and ensure access to highly specialized patient care.

Washington University Medical Center is one of the world's premier centers of health care, research, education and community service. Its institutions are Washington University School of Medicine, Barnes-Jewish Hospital, Barnard Free Skin and Cancer Hospital, Central Institute of the Deaf and St. Louis Children's Hospital.

Academic health centers receive funding from many different sources. The primary sources of funding for Washington University School of Medicine are clinical revenue (private health insurance, Medicare and Medicaid) and research funds (primarily from federal sources).

There is a real concern that price competition in the health care market will undercut our ability to conduct cutting-edge research, teach the next generation of physicians and other health care providers and provide clinical care to all who come to our door.

Until now, medical schools have been able to use their clinical revenue to support education, research and care for the medically indigent. A recent study conducted by the Association of American Medical Colleges estimated that 28 cents of every faculty-practice-plan dollar supports medical school academic programs. This will change as managed care penetrates the market and purchasers continue to reap the benefits of, become less willing to pay for the costs of research and education associated with AHCs.

Furthermore, changes in federal government policies are hurting the hospitals with which medical schools are affiliated. Medicare contributes to the "mission-related activities" of teaching hospitals through payments for graduate medical education (including direct and indirect components - DME and IME), and disproportionate share (DSH) payments. When Medicare recipients choose to enroll in managed care plans, the adjusted average per capita cost calculation (AAPCC) paid to the insurance company includes these mission related payments. Once these payments are included in the AAPCC, the contractor has no requirement to pass them on to academic health centers. We believe these mission-related payments should be carved out of the AAPCC and paid to the institutions that Congress intended.

Finally, many people believe that Medicare pays more than its fair share of graduate medical education costs. Since all health care recipients are beneficiaries of the research, education and high-technology patient care that takes place at AHCs, we believe all payers should contribute to a fund for payment of these societal goods.

AHCs are doing many things to respond to the external forces we face. We are reducing expenses, reorganizing our practices, joining with integrated health systems and partnering with community physicians. We are investing more in generalist practices and revising clinical education, and we are developing case management for best practices and emphasizing outcomes measurement.

Despite these successful efforts at significant cost control, AHCs like Washington University Medical Center will continue to have higher costs because of the types of patients we treat (severely ill and medically disadvantaged), the residents who are in training and the comprehensive and intensive services we offer. The future quality of health care for all Americans could suffer unless change at academic health centers is undertaken in a thoughtful, supportive manner.

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